

HIV and COVID-19: Getting to Zero through Greater Health Equity

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Both HIV & COVID-19 disproportionately impact communities of color

HIV

THE LIFETIME RISK OF ACQUIRING HIV:

BLACK/AFRICAN AMERICAN

MSM: 1 in 2
Transgender Women: 1 in 2
Men: 1 in 22
Women: 1 in 54

HISPANIC/LATINX

MSM: 1 in 5
Transgender Women: 1 in 6
Men: 1 in 51
Women: 1 in 256

AMERICAN INDIAN/ALASKA NATIVE

MSM: 1 in 12
Transgender Women: N/A
Men: 1 in 131
Women: 1 in 403

WHITES

MSM: 1 in 11
Transgender Women: 1 in 6
Men: 1 in 140
Women: 1 in 941



COVID-19

ELEVATED RISK COMPARED TO WHITE AMERICANS:

BLACK/AFRICAN AMERICAN

Cases: 2.6x higher
Hospitalizations: 4.7x higher
Deaths: 2.1x higher

HISPANIC/LATINX

Cases: 2.8x higher
Hospitalizations: 4.6x higher
Deaths: 1.1x higher

AMERICAN INDIAN/ALASKA NATIVE

Cases: 2.8x higher
Hospitalizations: 5.3x higher
Deaths: 1.4x higher

COVID-19 is part of a syndemic that magnify health inequities by race

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ELSEVIER

Commentary

Understanding COVID-19 risks and vulnerabilities among black communities in America: the lethal force of syndemics

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ABSTRACT

Black communities in the United States are bearing the brunt of the COVID-19 pandemic and the underlying conditions that exacerbate its negative consequences. Syndemic theory provides a useful framework for understanding how such interacting epidemics develop under conditions of health and social disparity. Multiple historical and present-day factors have created the syndemic conditions within which black Americans experience the lethal force of COVID-19. These factors include racism and its manifestations (e.g., chattel slavery, mortgage redlining, political gerrymandering, lack of Medicaid expansion, employment discrimination, and health care provider bias). Improving racial disparities in COVID-19 will require that we implement policies that address structural racism at the root of these disparities.

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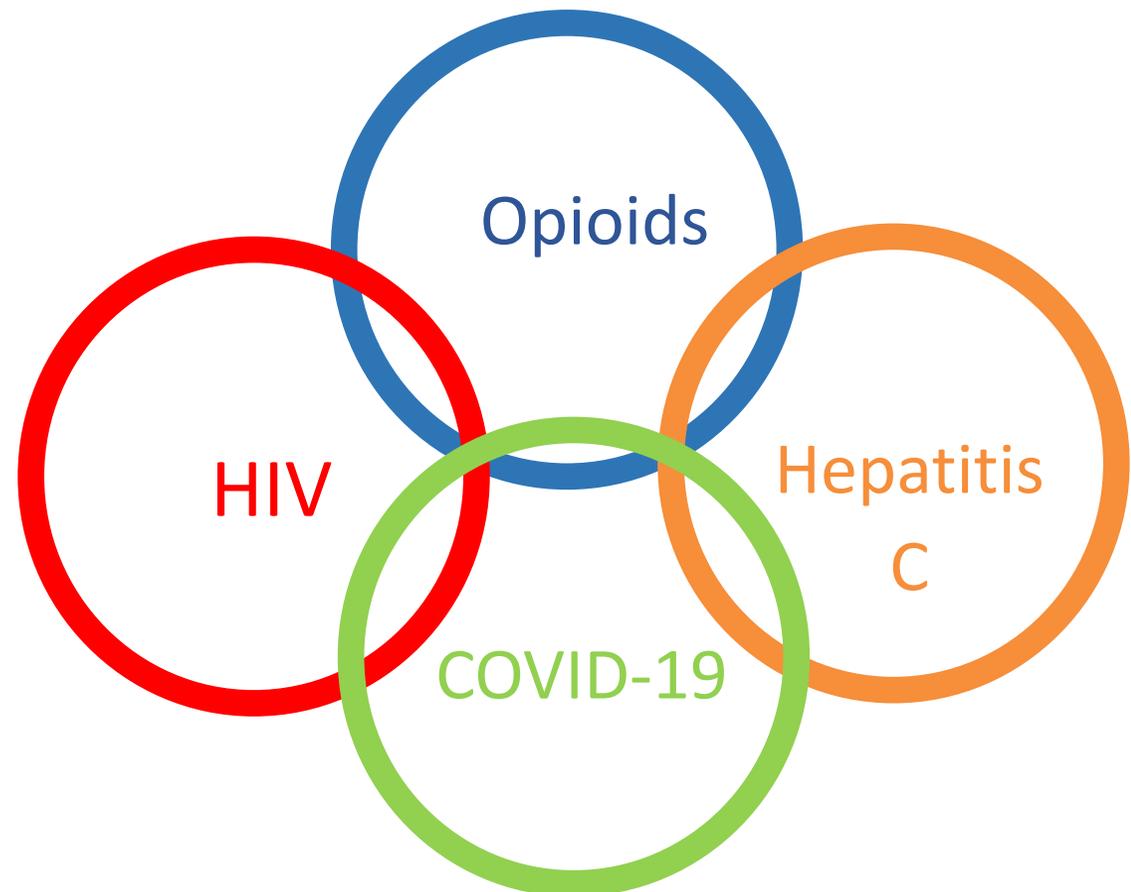
As COVID-19 cases have exploded in the United States, stark racial disparities in morbidity and mortality have emerged. The burden is most pronounced for black Americans who make up 13% of the U.S. population but 30% of COVID-19 cases in the 14 states for which racial data were available [1]. Rates of exposure and infection with the novel pathogen may also differ by race; however, the lack of widespread testing and limited reporting of racial data make this difficult to ascertain. A variety of explanations have been offered for this emerging health inequity: Black Americans experience a higher prevalence of underlying chronic conditions, such as hypertension (57%) [2], diabetes (18%) [3], and obesity (50%) [4], which predispose individuals to poorer clinical outcomes, including death, in the event of COVID-19 disease [5]. Black Americans are 1.5 times more likely to be underinsured or lack health insurance altogether than whites [6], contributing to delayed access to lifesaving care [7]. On April 17, 2020, U.S. Surgeon General Jerome Adams even suggested black Americans have higher substance use rates and recommended they reduce substance use, alcohol consumption, and smoking to prevent COVID-19 deaths [8]. While these factors may play a role in why black American communities face greater losses in this pandemic, decades of research to understand the disproportionate burden of HIV among black Americans may help unmask the drivers of this inequity and improve efforts to mitigate it.

It is a longstanding paradox that black Americans carry the highest burdens of HIV while also reporting similar rates of HIV risk behaviors as other groups. This holds true for black American men who have sex with men as well as for black American women [9,10]. Syndemic theory has provided a useful framework for understanding this paradox [11]. Anthropologist Merrill Singer first proffered syndemic theory as a way “to elucidate the tendency for multiple co-terminus and interacting epidemics to develop under conditions of health and social disparity” [12]. The high rate of COVID-19 exposure, acquisition, and mortality among black Americans represents “multiple co-terminus and interacting epidemics” occurring within persistent national health and social inequities already impacting black communities. Multiple historical and present-day factors have created the syndemic conditions within which black Americans experience the lethal force of COVID-19.

The health impact of social and political decisions outweighs the impact of individual choices, and these decisions have a historical context. Sociological and economic studies have shown correlations between modern-day attitudes and policies in former confederate

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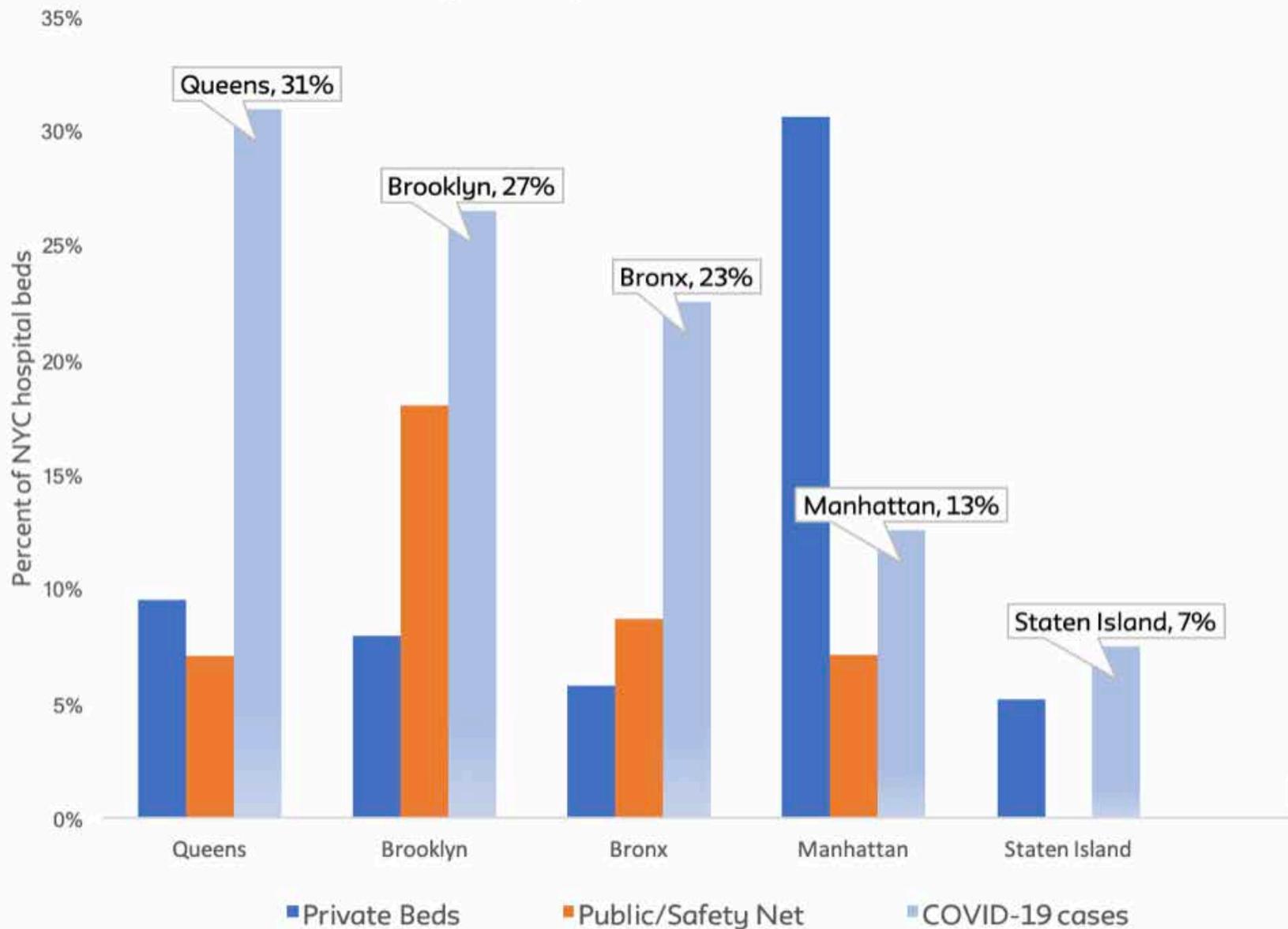
PROCEEDINGS OF A WORKSHOP

INVESTING IN INTERVENTIONS THAT ADDRESS NON-MEDICAL, HEALTH-RELATED SOCIAL NEEDS

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

- “...while health care accounts for some 10 to 20 percent of the determinants of health, socioeconomic factors and factors related to the physical environment are estimated to account for up to 50 percent of the determinants of health”

Distribution by borough of NYC hospital beds & COVID-19 cases

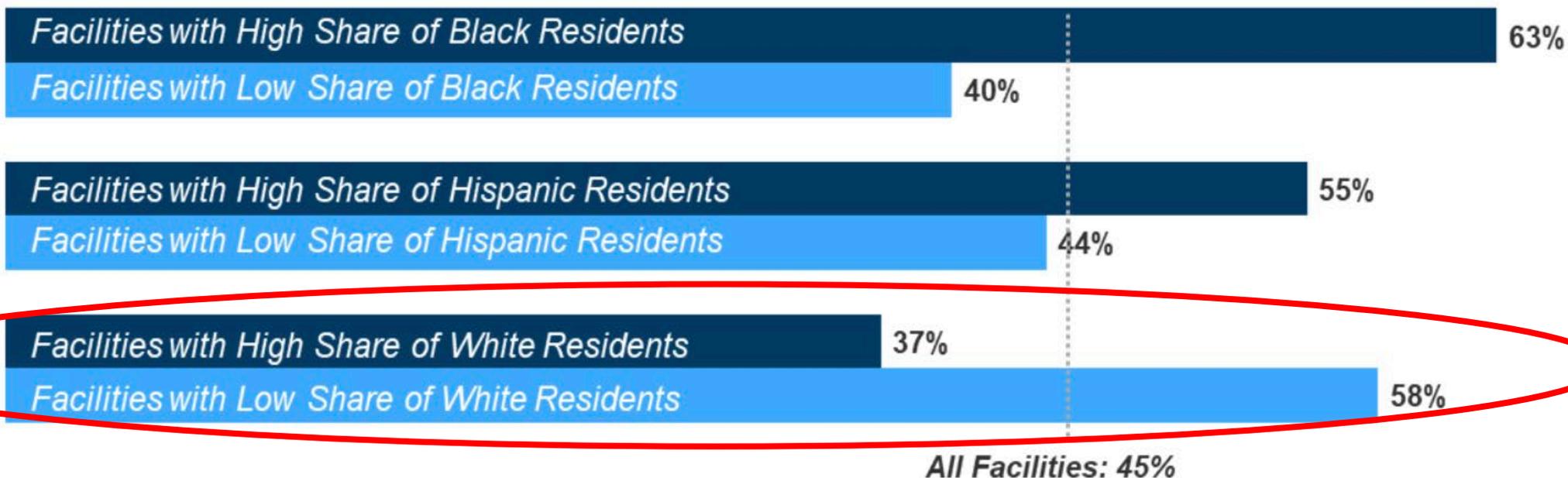


Sources: COVID-19 case count by borough as of April 25, 2020 <https://www1.nyc.gov/site/doh/covid/covid-19-data.page>
NYC Hospital bed counts https://profiles.health.ny.gov/hospital/county_or_region/ Categorized by author

Figure 1

Nursing Homes With Relatively High Shares of Black or Hispanic Residents Were More Likely To Have At Least One COVID-19 Death

Share of Nursing Homes With At Least One COVID-19 Death (as of October 11, 2020):

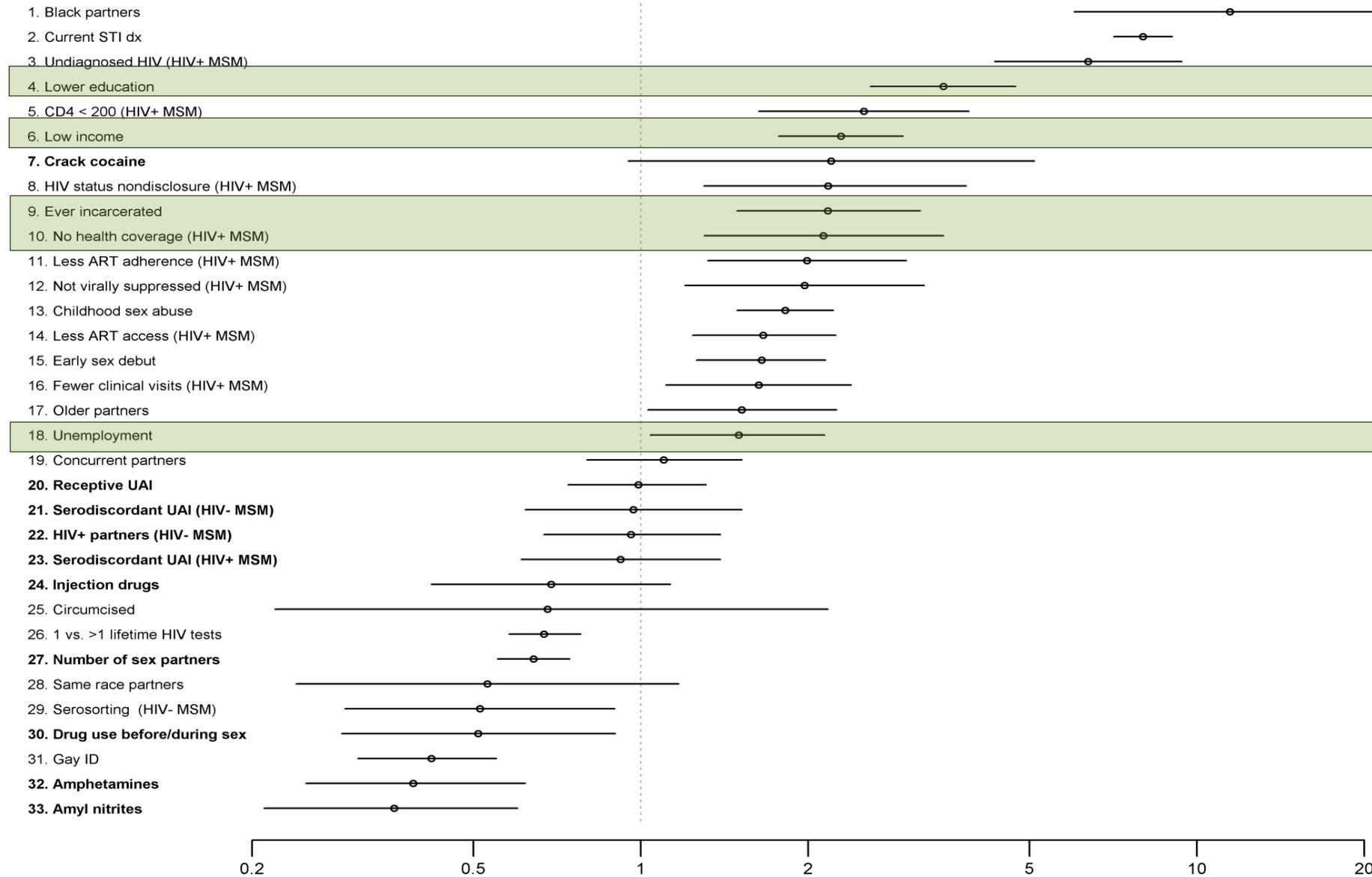


NOTES: Includes 13,982 nursing homes for which race/ethnicity data were available for all groups and for which resident cases or deaths were not > total number of beds. High share of Black residents or Hispanic residents refers to 20% or more. High share of White residents is 80% or more. Facilities may fall into more than one of these groups.

SOURCE: KFF analysis of Shaping Long Term Care in America Project at Brown University funded in part by the National Institute on Aging (1P01AG027296), CMS COVID-19 Nursing Home Data (as of October 11, 2020)

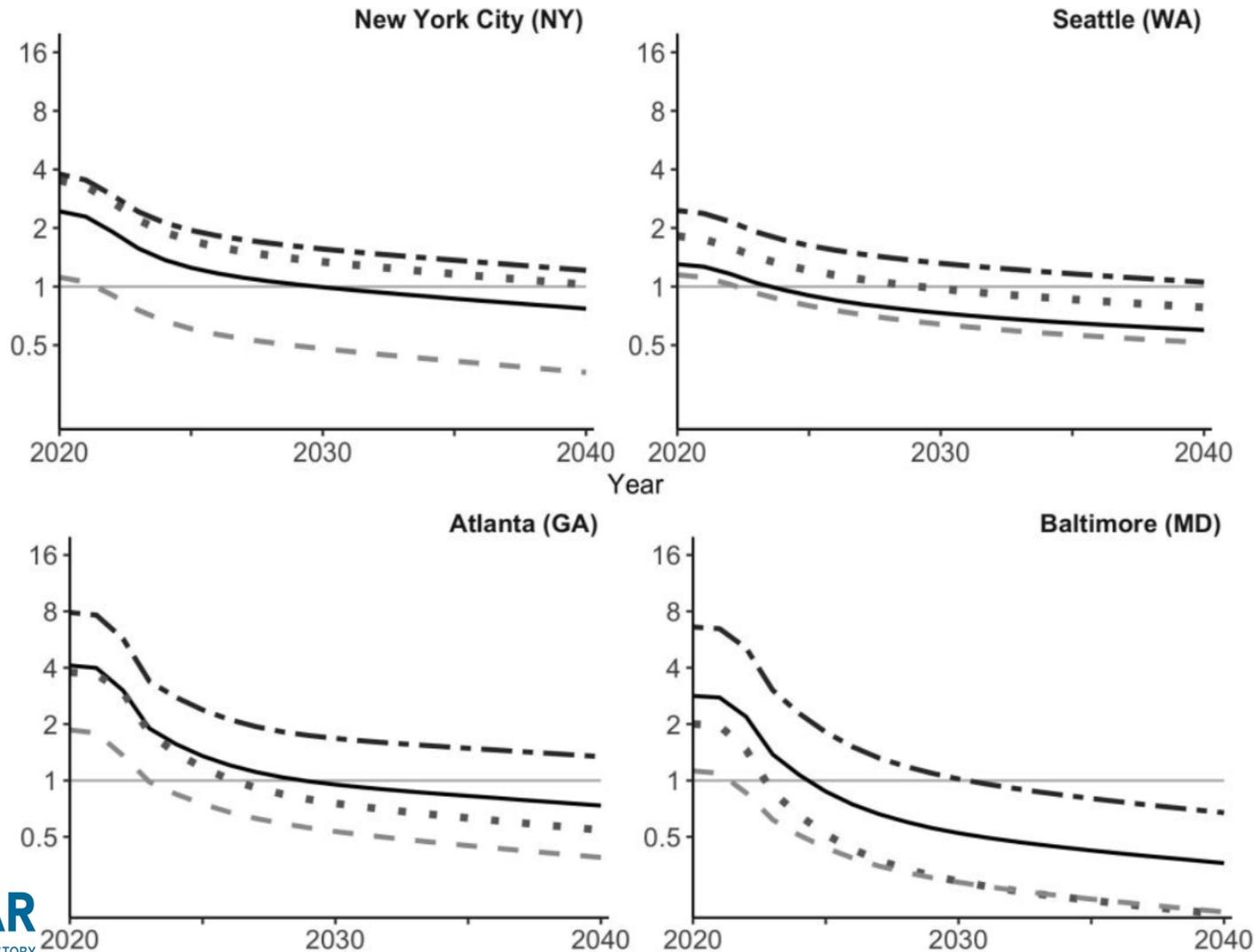
HIV-Risks of Evaluated ORs by Evaluated Factors Black MSM (Social Determinants)

THE LANCET

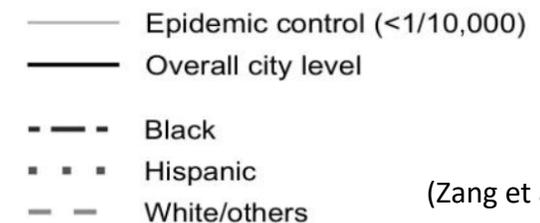


(Millett, The Lancet, 2012)

We are on track to end the HIV epidemic with White Americans

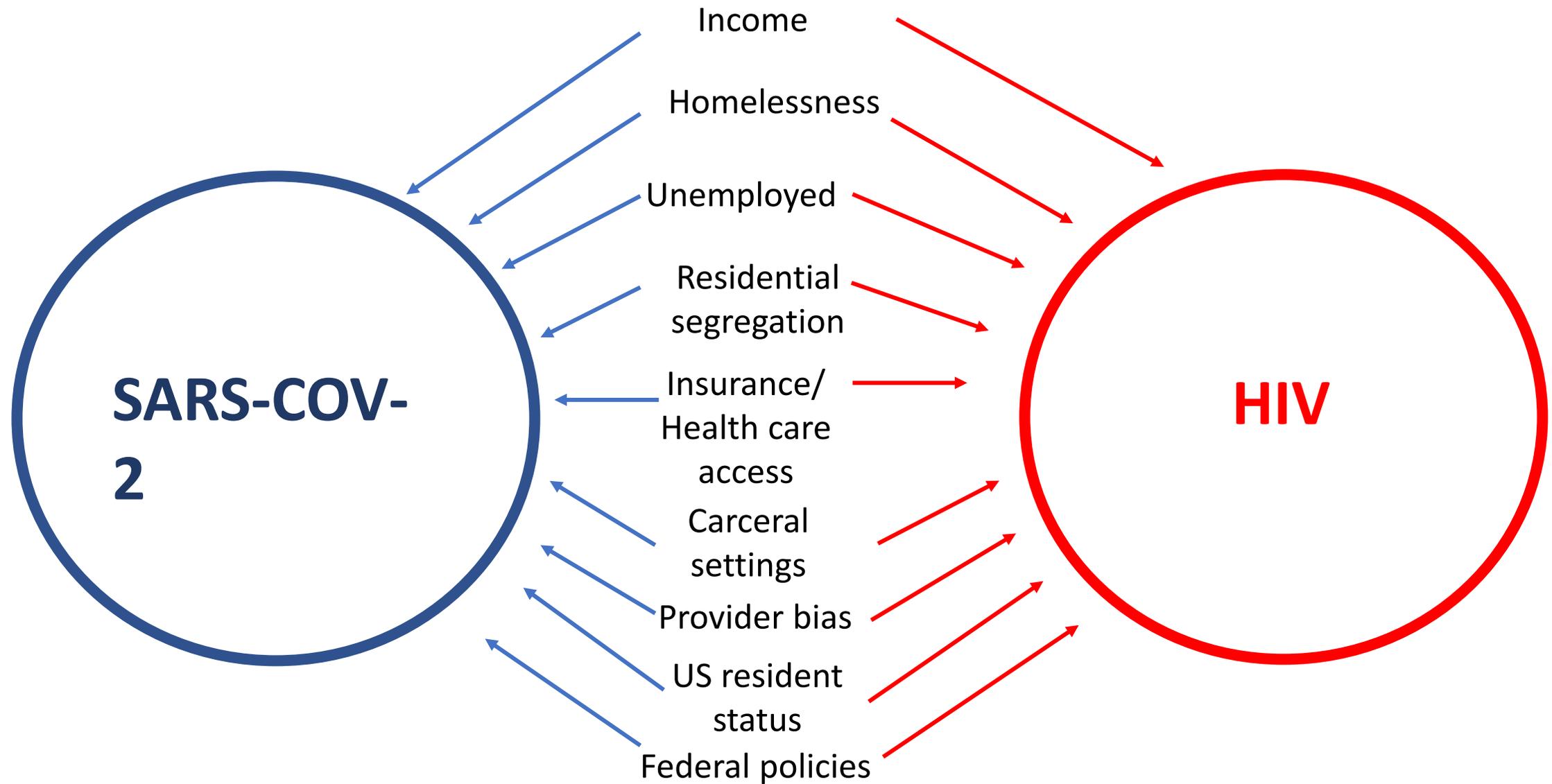


- These estimates were made *pre-COVID*.
- It will take much longer to end HIV in black and brown communities due to COVID-19 delays



(Zang et al, 2020)

Social determinants of health
that magnify health inequities



Social Determinants of Health & HIV Racial Disparities

OPEN ACCESS Freely available online

PLOS ONE

Beyond Race and Place: Distal Sociological Determinants of HIV Disparities

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Abstract

Informed behavior change as an HIV prevention tool has yielded unequal successes across populations. Despite decades of HIV education, some individuals remain at high risk. The mainstream media often portrays these risk factors as products of race and national borders; however, a rich body of recent literature proposes a host of complex social factors that influence behavior, including, but not limited to: poverty, income inequality, stigmatizing social institutions and health care access. We examined the relationship between numerous social indicators and HIV incidence across eighty large U.S. cities in 1990 and 2000. During this time, major correlating factors included income inequality, poverty, educational attainment, residential segregation and marriage rates. However, these ecological factors were weighted differentially across risk groups (e.g. heterosexual, intravenous drug use, men who have sex with men (MSM)). Heterosexual risk rose significantly with poor economic indicators, while MSM risk depended more heavily on anti-homosexual stigma (as measured by same-sex marriage laws). HIV incidence among black individuals correlated significantly with numerous economic factors but also with segregation and imbalances in the male:female ratio (often an effect of mass incarceration). Our results support an overall model of HIV ecology where poverty, income inequality and social inequality (in the form of institutionalized racism and anti-homosexual stigma) have over time developed into synergistic drivers of disease transmission in the U.S., inhibiting information-based prevention efforts. The relative weights of these distal factors vary over time and by HIV risk group. Our testable model may be more generally applicable within the U.S. and beyond.

Citation: Buot M-LG, Docena JP, Ratemo BK, Bittner MJ, Burlew JT, et al. (2014) Beyond Race and Place: Distal Sociological Determinants of HIV Disparities. PLOS ONE 9(4): e91711. doi:10.1371/journal.pone.0091711

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Introduction

"Know your epidemic" was the charge given by the 2007 Joint United Nations Programme on HIV/AIDS, as it noted that the human behaviors promoting HIV transmission are significantly influenced by cultural and structural variations within and across societies [1]. A significant characteristic of HIV incidence in the United States is its racial disparity, with black and Hispanic individuals bearing a disproportionate burden of new infections [2]. Variations in sexual behaviors between black and white individuals (e.g. partner numbers, age of sexual debut) cannot fully explain this [3,4,5,6].

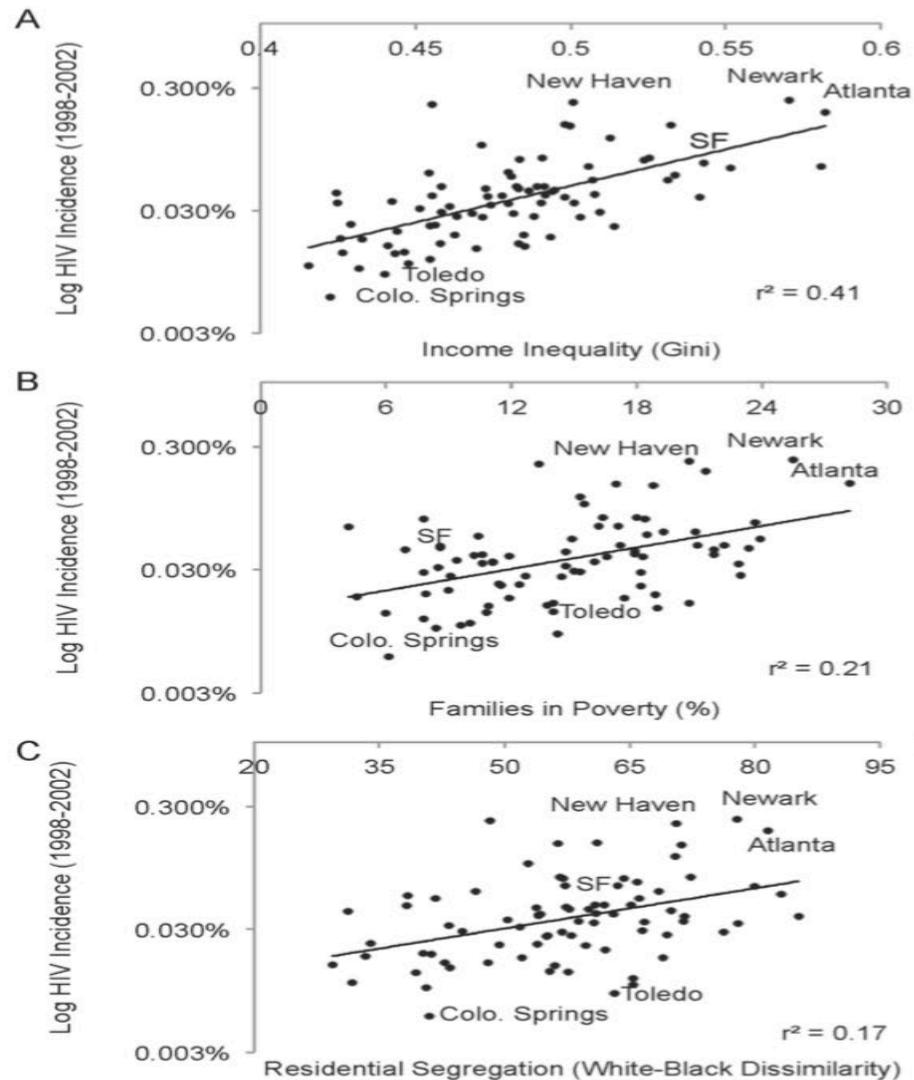
Poverty has emerged as a major force in promoting the transmission of HIV around the world [7,8,9]. In the U.S., poverty and HIV are associated [10,11,12], and impoverished urban areas have HIV prevalence rates equivalent to those of many low-income countries with generalized epidemics [11]. However, the strength of the connection between poverty and HIV has recently been called into question, as HIV prevalence rates have been found to positively correlate with wealth within some sub-Saharan African countries [13,14,15]. Income inequality, however, has

remained a stable predictor of HIV across nations, though why remains poorly understood [7,16,17].

Socioeconomic status can explain a significant degree—but not all—of the U.S. racial disparities in sexually transmitted infections such as HIV [10,18]. Hogben and Leichter [19] have proposed residential segregation as an underlying social determinant of multiple other disparities that increase HIV incidence, including reduced health care access, higher incarceration rates and stigma. Economic instability and male:female ratios skewed by male incarceration may contribute to risky concurrent partnerships [20,21,22,23].

A growing body of literature supports the need to understand how HIV epidemics change over space and time [24]. The U.S. epidemic began in the subpopulation of men who have sex with men (MSM), a group that still accounts for a slim majority of HIV infections [2,25], yet has proportionately declined over the past two decades. Young, non-white and poor MSM remain particularly at risk [26]. Some have proposed that covert ("down low") MSM activity is partially responsible for this discrepancy, though this remains a subject of controversy [27,28].

Much of what we know about the ecology of HIV risk comes from time- and personnel-intensive individual interviews and



Associations with HIV incidence in black communities

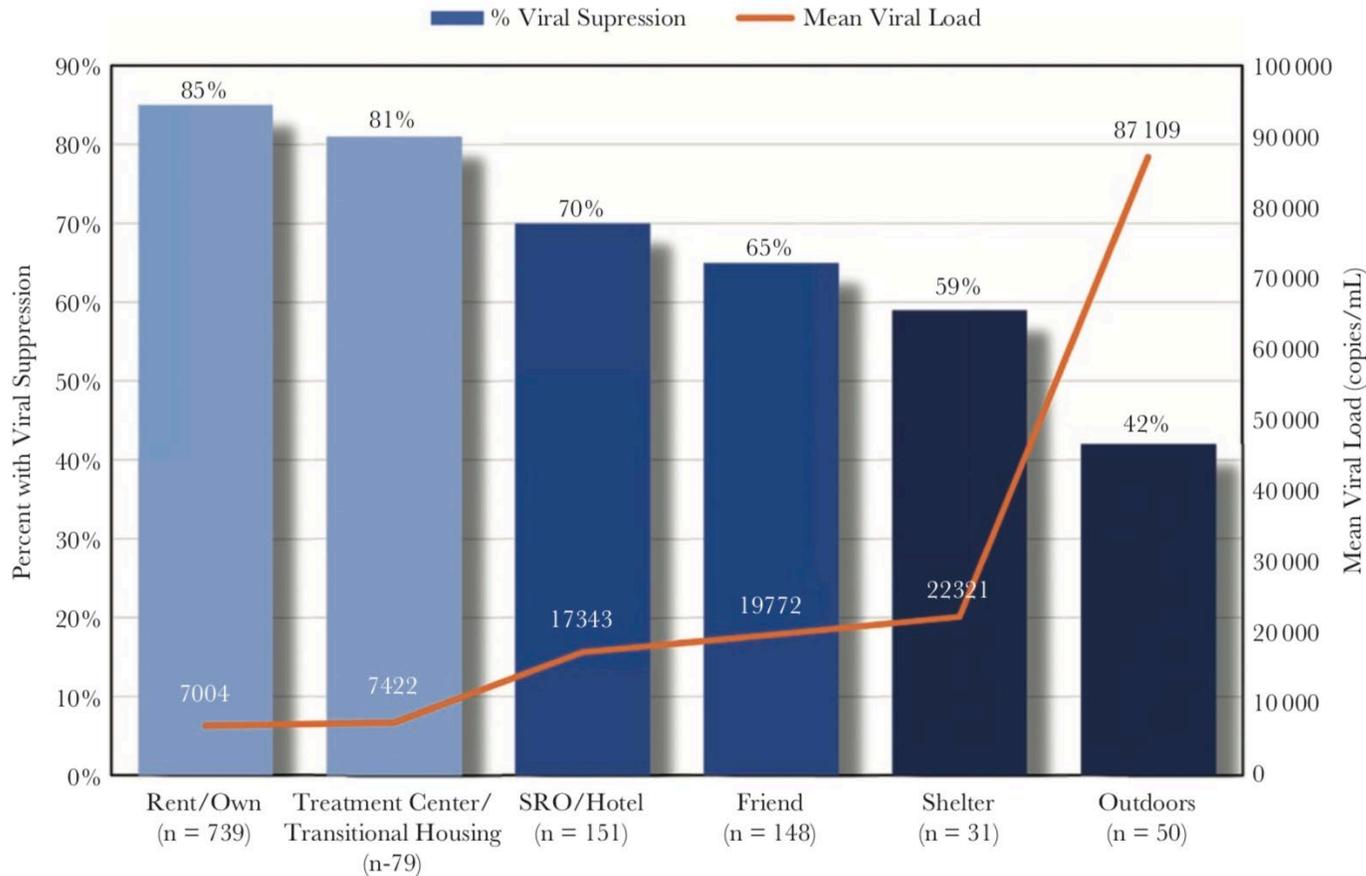
Poverty (RR 8.5, 95%CI 3.7-23.8)

Vacant housing (RR 5.7, 95% CI 2.6-14.1)

Unemployment (RR 9.6, 95% CI 4.2-43.3)

Black isolation (RR 54.12, 30.5-95.7)

Homelessness and HIV outcomes may worsen due to the COVID-19 Recession



aOR (95% CI)	Reference	0.97 (0.52, 1.81)	0.49 (0.32, 0.73)	0.38 (0.25, 0.57)	0.27 (0.13, 0.60)	0.16 (0.09, 0.30)
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(Clemenzi-Allen, 2019)

CONCISE COMMUNICATION

Homelessness at diagnosis is associated with death among people with HIV in a population-based study of a US city

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Ling Hsu^c, Maree-Kay Parisi^c, Sharon Pipkin^c, Susan Scheer^c,
Diane Havlir^a and Susan P. Buchbinder^c

Objective: San Francisco, California, has experienced a 44% reduction in new HIV diagnoses since 2013 supported by its 'Getting to Zero' initiative; however, the age-adjusted mortality rate in people with HIV (PWH) has not decreased. We sought to identify factors associated with death among PWH in San Francisco.

Design: Population-based incidence-density case-control study.

Methods: Among PWH in the San Francisco HIV surveillance registry, a random sample of 48 decedents from 1 July 2016 to 31 May 2017 were each matched to two to three controls who were alive at the date of death (108 controls matched on age and time since diagnosis). Covariates included demographics, substance use, housing status, medical conditions, and care indicators from the study population. We used matched-pair conditional logistic regression to examine factors associated with mortality.

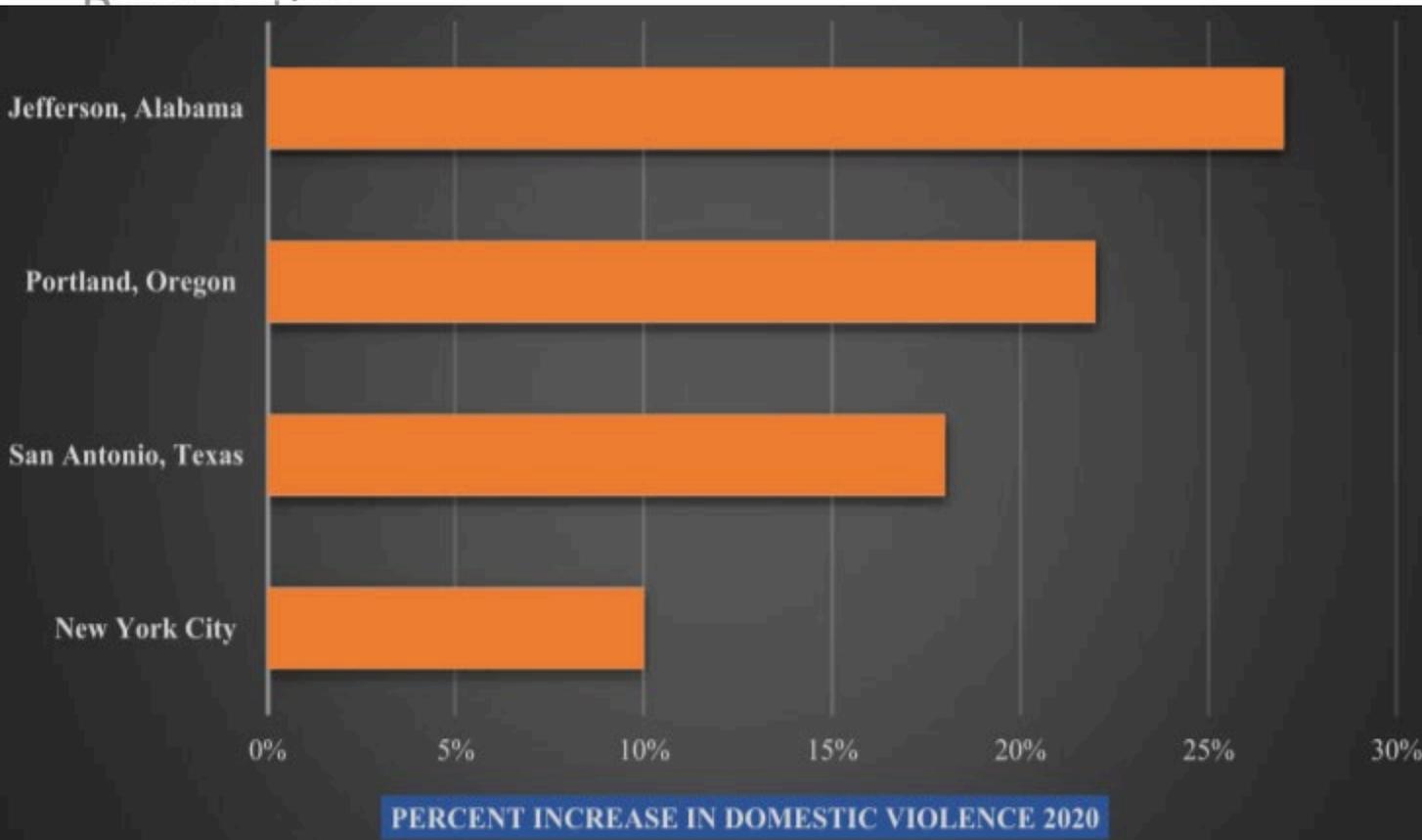
Results: Of the 156 PWH in the study, 14% were African-American, 14% Latino, and 8% female sex. In adjusted analysis, factors associated with higher odds of death included: homelessness at HIV diagnosis [adjusted odds ratio (AOR) = 27.4; 95% confidence interval (CI) = 3.0–552.1], prior-year IDU (AOR = 10.2; 95% CI = 1.7–128.5), prior-year tobacco use (AOR = 7.2; 95% CI = 1.7–46.9), being off antiretroviral therapy at any point in the prior year (AOR = 6.8; 95% CI = 1.1–71.4), and being unpartnered vs. married/partnered (AOR = 4.7; 95% CI = 1.3–22.0).

Conclusion: People homeless at HIV diagnosis had 27-fold higher odds of death compared with those with housing; substance use and retention on antiretroviral therapy in the prior year are other important intervenable factors. New strategies to address these barriers, and continued investment in supportive housing and substance use treatment, are needed. Copyright © 2019 Wolters Kluwer Health, Inc. All rights reserved.

AIDS 2019, 33:1789–1794

Keywords: antiretroviral therapy, HIV, homelessness, mortality, preventable mortality, substance use

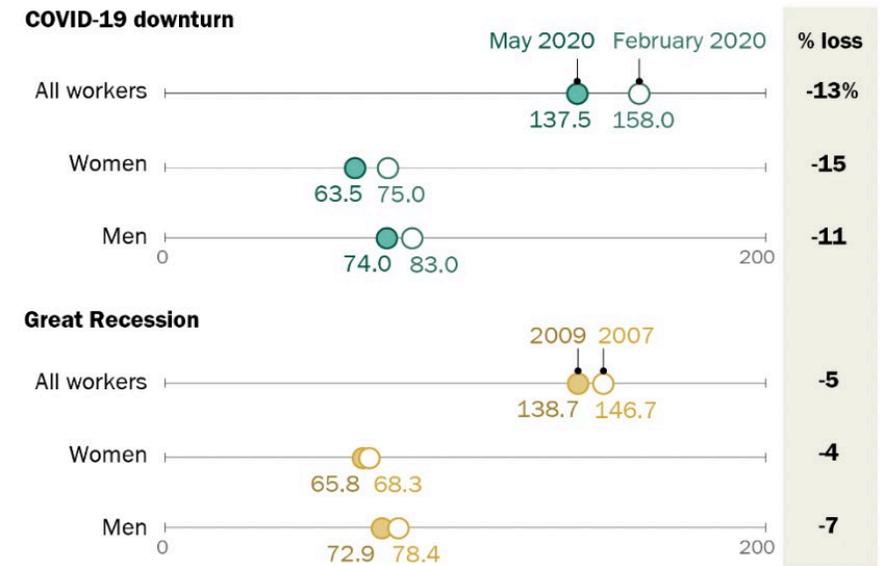
The COVID-19 Recession and Women



drop in caseloads are likely to experience a second surge. This pandemic has reinforced important truths: inequities related to social determinants of health are magnified during a crisis, and sheltering in

Women have lost more jobs than men in COVID-19 downturn, a reversal from the Great Recession

Employed workers, in millions



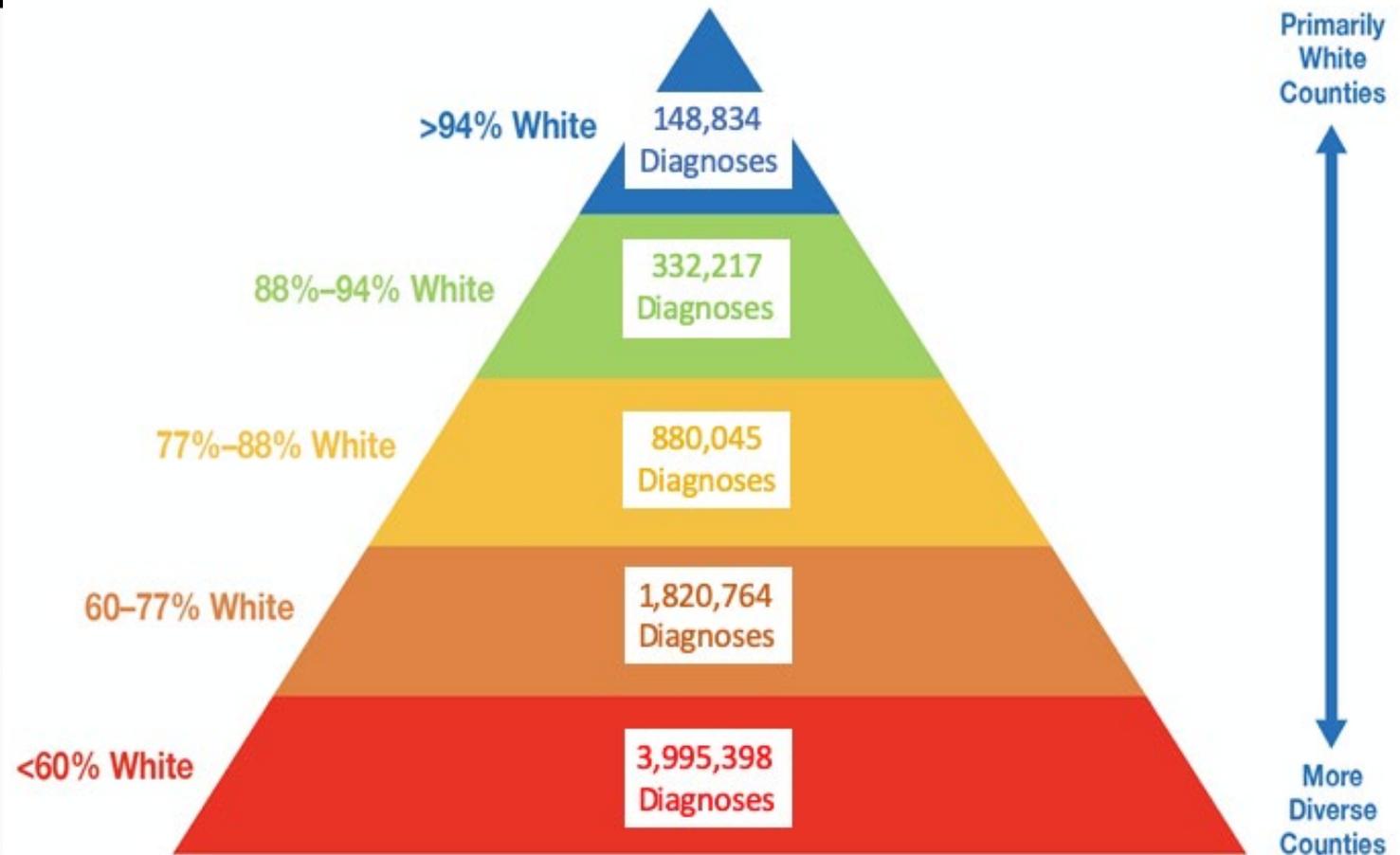
Note: Estimates refer to employed workers ages 16 and older, nonseasonally adjusted. Estimates for 2007 and 2009 refer to the fourth quarter of each year. Source: Bureau of Labor Statistics and Pew Research Center analysis of 2007 and 2009 Current Population Survey data.

PEW RESEARCH CENTER

COVID-19 and Residential Segregation

National

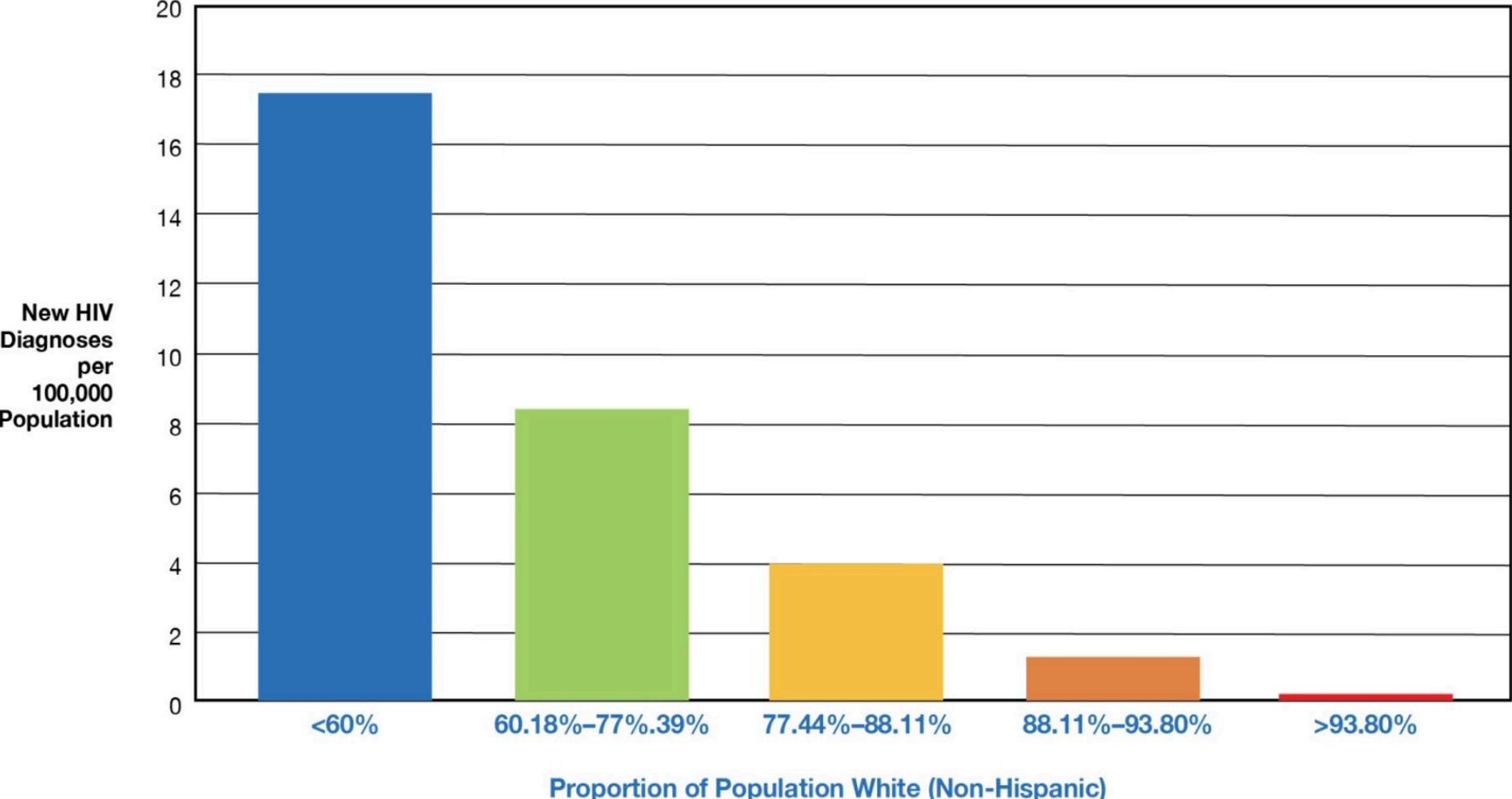
Residential segregation plays a role in coronavirus disparities, study finds



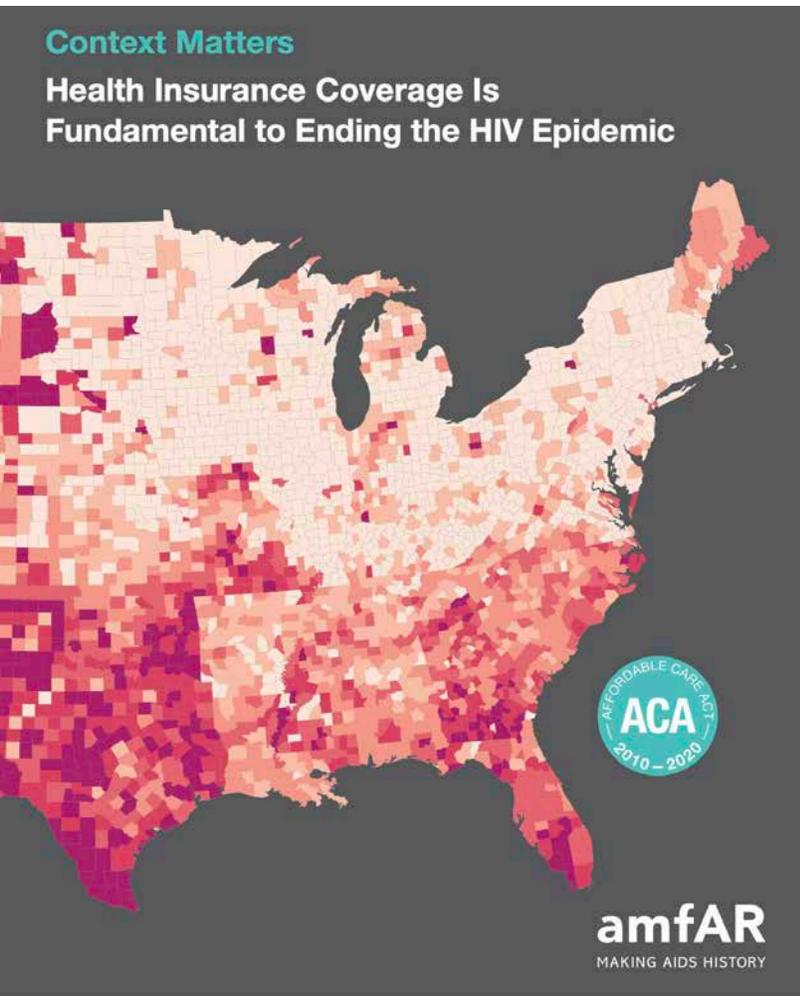
(Millett et al, 2020)

As with COVID-19, HIV diagnoses are highest in more diverse counties (fewer whites) and lowest in counties with more white residents.

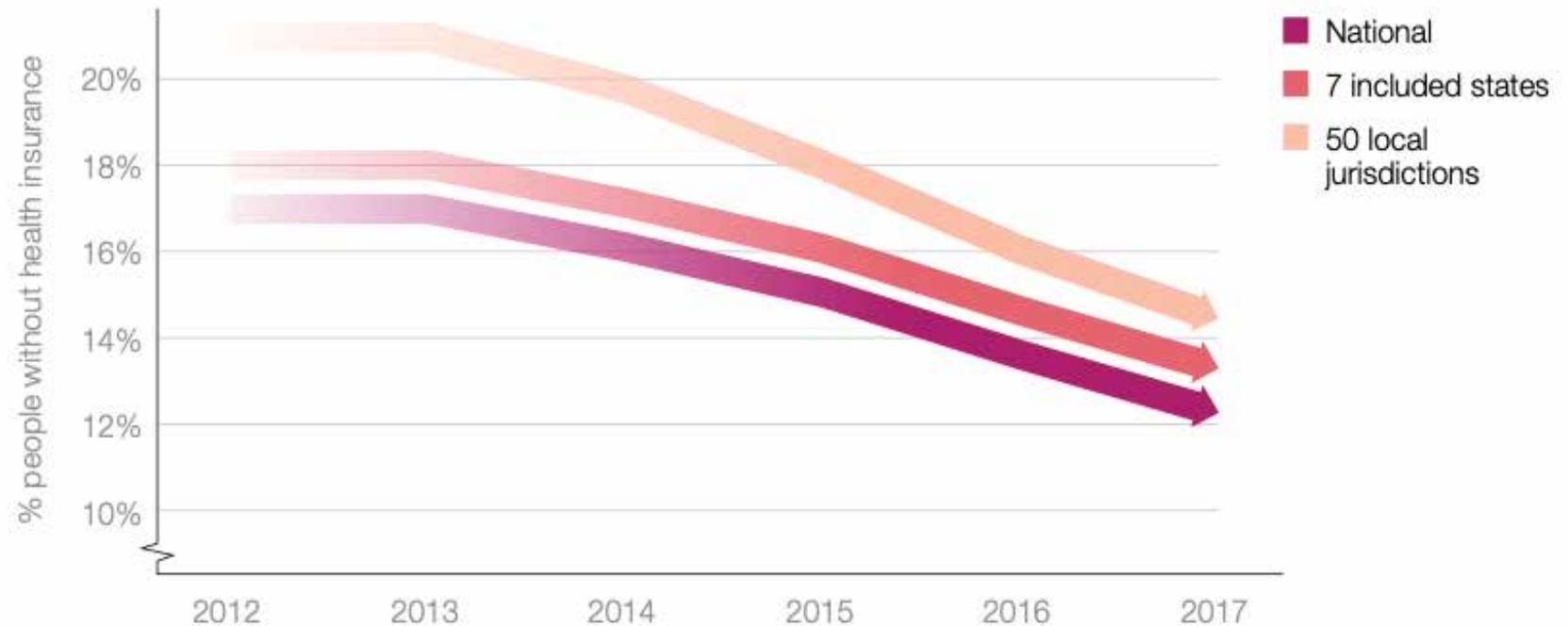
Both COVID-19 and HIV disproportionately impact communities of color. Residential segregation, structural racism and social determinants of health drive diagnoses in nonwhite communities.



The centrality of health insurance in health equity

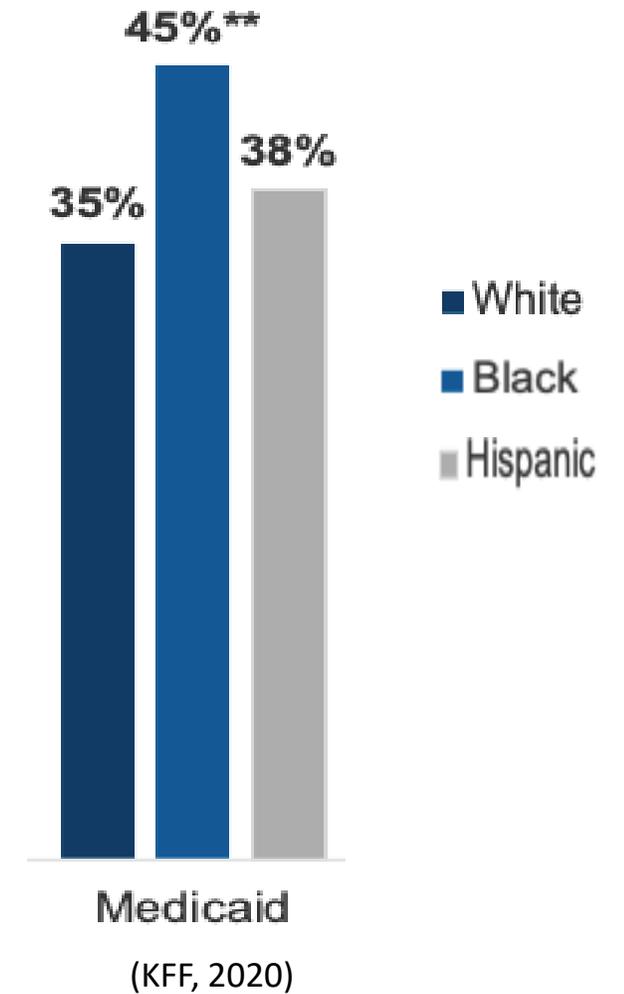
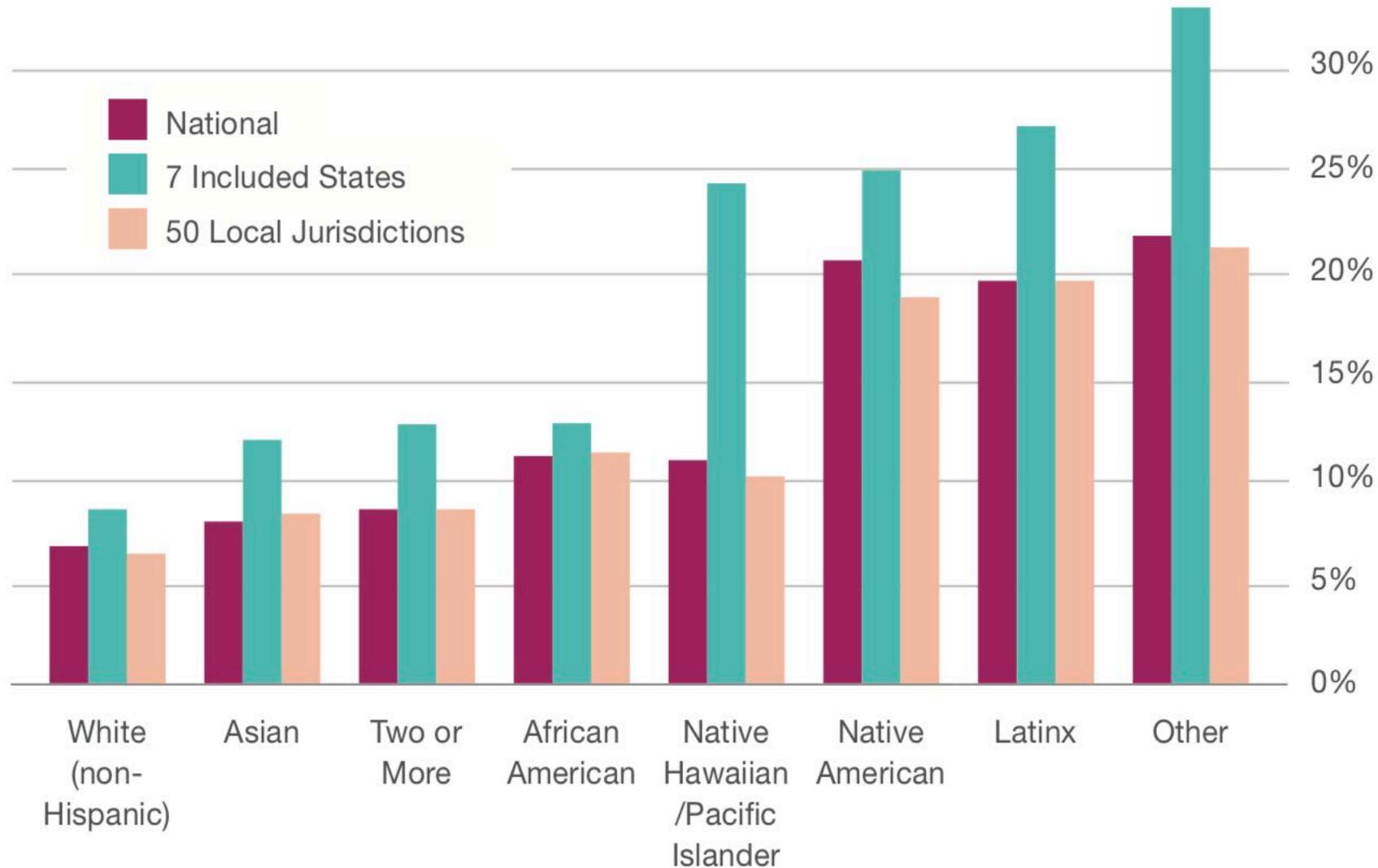


The percentage of uninsured Americans dropped from 2012 through 2017, but EHE locations lagged behind the nation as a whole.



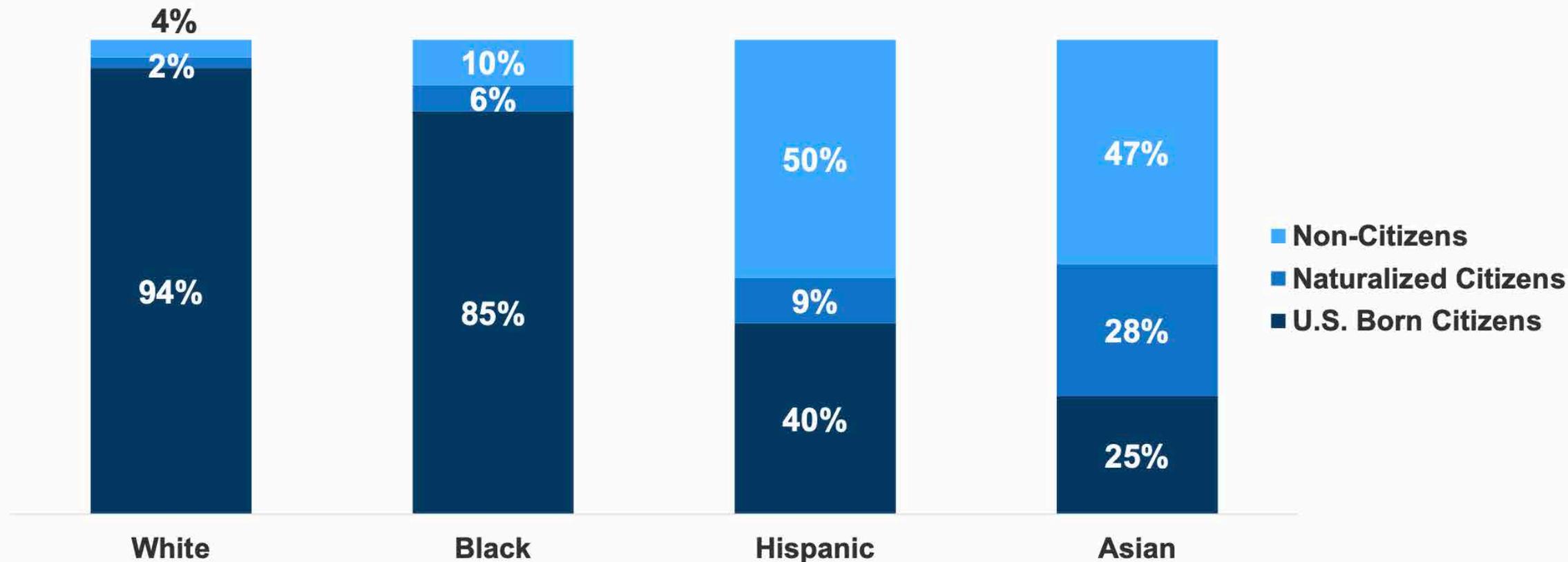
(US Census data; amfAR EHE database)

Percent of Uninsured is Highest in The 7 EHE States



Source: ehe.amfar.org

Citizenship Status of Nonelderly Uninsured Population by Race/Ethnicity, 2018



Note: Numbers may not sum due to rounding. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic. Includes nonelderly individuals 0-64 years of age. All values have a statistically significant difference from the White population at the $p < 0.05$ level.

Source: KFF analysis of 2018 American Community Survey, 1-Year Estimates.

Non-English Speakers and HIV/ COVID-19 risk

PLOS ONE

RESEARCH ARTICLE

County-level factors affecting Latino HIV disparities in the United States

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Abstract

Objective
To determine which county-level factors are associated with higher rates of diagnosed HIV infection.

Methods and findings
We used 2016 county-level data on HIV prevalence and non-Latino Whites obtained from multiple sources. We examined the association of observed HIV prevalence with county-level factors. Overall, the mean HIV prevalence was 10.1%. Whites had higher rates for HIV than non-Whites. Of the 41 factors examined, 10 had significant effects on HIV prevalence. Factors that increased HIV prevalence compared to lower values included proportion of HIV diagnoses due to injection drug use, percent Latino living in poverty, percent not English proficient, and percent Puerto Rican. Latino disparities increased with decreasing percent severe housing, drug overdose mortality rate, percent rural, female prevalence rate, social association rate, percent change in Latino population, and Latino to NL-White proportion of the population. These factors while significant had minimal effects on diminishing disparity, but did substantially reduce the variance in disparity rates.

OPEN ACCESS
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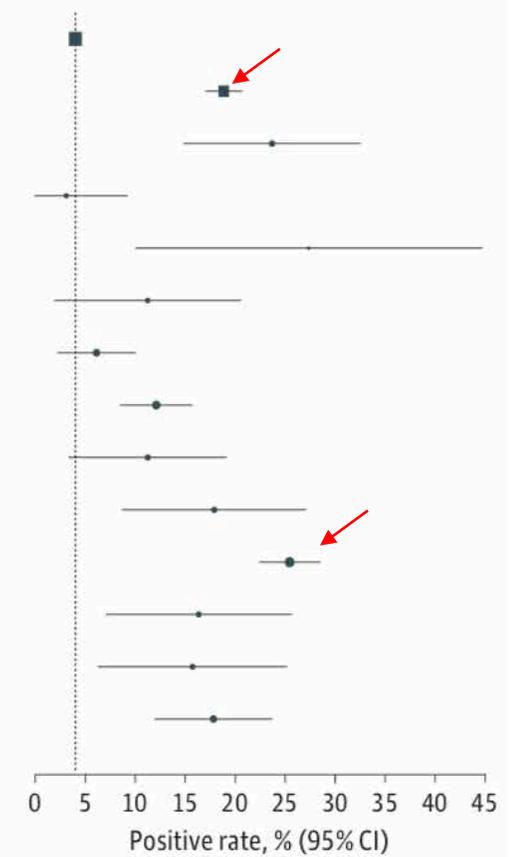
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Data Availability Statement: All data in this study are publicly available and can be found here: <https://doi.org/10.1371/journal.pone.0237269>

Factors that increased inequities with higher compared to lower values included proportion of HIV diagnoses due to injection drug use, percent Latino living in poverty, percent not English proficient

Figure 2. Proportion of Patients Testing Positive for Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) by Language

Language	No. tested	Positive rate, % (95% CI)
English	1154	4 (3.8-4.2)
Non-English	347	18.6 (16.8-20.3)
Amharic	21	23.3 (14.6-32.1)
Arabic	1	3.1 (0-9.2)
Cambodian/Khmer	7	26.9 (9.9-44)
Korean	5	11.1 (1.9-20.3)
Mandarin/Cantonese	9	6.1 (2.2-9.9)
Other	38	11.9 (8.4-15.5)
Russian	7	11.1 (3.4-18.9)
Somali	12	17.6 (8.6-26.7)
Spanish	199	25.1 (22-28.1)
Tagalog	10	16.1 (7-25.3)
Tigrinya	9	15.5 (6.2-24.8)
Vietnamese	29	17.6 (11.8-23.4)



Travel, HIV services and retention/ viral suppression

AIDS Behav
DOI 10.1007/s10461-013-0597-7

ORIGINAL PAPER

Travel Distance to HIV Medical Care: A Geographic Analysis of Weighted Survey Data from the Medical Monitoring Project in Philadelphia, PA

M. G. Eberhart · C. D. Voytek · A. Hillier ·
D. S. Metzger · M. B. Blank · K. A. Brady

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Abstract Decisions regarding where patients access HIV care are not well understood. The purpose of this analysis was to examine differences in travel distance to care among persons receiving care in Philadelphia. A multi-stage sampling design was utilized to identify 400 potential participants. 65 % (260/400) agreed to be interviewed. Participants were asked questions about medical care, supportive services, and geographic location. Distances were calculated between residence and care location. 46.3 % travelled more than three miles beyond the nearest facility. Uninsured travelled further (6.9 miles, 95 % CI 3.9–9.8) than persons with public insurance (3.3 miles, 2.9–3.6). In multivariate analyses, no insurance (20/260) was associated with increased distance ($p = 0.0005$) and Hispanic ethnicity was associated with decreased distance ($p = 0.0462$). Persons without insurance travel further but insurance status alone does not explain the variability in distance travelled to care. In Philadelphia, Hispanic

populations, and providers that may be most accessible to care are not well understood. The purpose of this analysis was to examine differences in travel distance to care among persons receiving care in Philadelphia. A multi-stage sampling design was utilized to identify 400 potential participants. 65 % (260/400) agreed to be interviewed. Participants were asked questions about medical care, supportive services, and geographic location. Distances were calculated between residence and care location. 46.3 % travelled more than three miles beyond the nearest facility. Uninsured travelled further (6.9 miles, 95 % CI 3.9–9.8) than persons with public insurance (3.3 miles, 2.9–3.6). In multivariate analyses, no insurance (20/260) was associated with increased distance ($p = 0.0005$) and Hispanic ethnicity was associated with decreased distance ($p = 0.0462$). Persons without insurance travel further but insurance status alone does not explain the variability in distance travelled to care. In Philadelphia, Hispanic

these studies varied by geographic location [6, 9], study population [1, 4, 6–8], and methodology [5, 10, 11], the general consensus is that distance is often a barrier to care [12]. More specifically, persons living in rural areas tend to travel greater distances than persons in urban areas [3, 10], and straight-line distances have been shown to be a reliable measure of actual distance travelled [10]. Geographic analyses have also been utilized to assess access to care by focusing on the distribution of medical care sites within a given jurisdiction or catchment area [2, 9, 11–17]. As a result, strategies that address equitable access to care often emphasize location in effort to reduce physical barriers [2, 14–18], when other factors may also impact where persons access care. Two factors commonly identified as influencing decisions regarding where to access medical care include race/ethnicity and socioeconomic status [1, 3, 5]. However, other factors which may be more difficult to measure and quantify, such as access to ancillary services, facility reputation, fear of unwanted disclosure, and geographic relationship to non-medical services, have also been identified [4, 6, 7].

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Identifying spatial variation along the HIV care continuum: The role of distance to care on retention and viral suppression

Terzian AS¹, Younes N¹, Greenberg AE¹, Opoku J², Hubbard J¹, Happ LP¹, Kumar P³,
Jones RR⁴, and Castel AD¹ DC Cohort Executive Committee

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Abstract

Background—Distance to HIV care may be associated with retention and viral suppression (VS) in Washington, DC.

Methods—RIC (≥ 2 HIV visits or labs ≥ 90 days) and VS (< 200 copies/mL at last visit) and distance to care were measured among 3,623 participants receiving HIV care in outpatient clinics in 2015. Logistic regression models and geospatial statistics were computed.

Results—RIC was 73%; 97% were on ART, among whom 77% achieved VS. ZIP code-level clusters of low RIC and high VS were observed in the Northwest; low VS in the Southeast. Those traveling ≥ 5 miles had 30% lower RIC (aOR=0.71, 95% CI: 0.58, 0.86) and lower VS (aOR=0.70, 95% CI: 0.52, 0.94).

Conclusions—Longer distances were associated with lower RIC and VS. Geospatial clustering of RIC

- DC cohort of 3,623 HIV+ participants receiving care.
- Those traveling ≥ 5 miles had 30% lower retention in care (aOR=0.71, 95% CI: 0.58, 0.86) and lower viral suppression

Racism and Racial Attitudes are Associated with Health Outcomes

The Washington Post
Democracy Dies in Darkness

National
Disproportionately black counties account for over half of coronavirus cases in the U.S. and nearly 60% of deaths, study finds

+ Add to list



PLOS ONE

RESEARCH ARTICLE

Race, explicit racial attitudes, implicit racial attitudes, and COVID-19 cases and deaths: An analysis of counties in the United States

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Abstract

Objectives

To examine the potential moderating effects of explicit racial attitudes and implicit racial attitudes on the relationship between percent of Black county residents and COVID-19 cases and deaths.

Methods

We collected data from a variety of publicly available sources for 817 counties in the US. (26% of all counties). Cumulative COVID-19 deaths and cases from January 22 to August 31, 2020 were the dependent variables; explicit racial attitudes and implicit racial attitudes served as the moderators; subjective poor or fair health, food insecurity, percent uninsured, percent unemployed, median family income, percent women, percent of Asian county resident, percent of Hispanic county residents, and percent of people 65 or older were controls.

Results

The percent of Black county residents was positively associated with COVID-19 cases and deaths at the county level. The relationship between percent of Black residents and COVID-19 cases was moderated by explicit racial attitudes and implicit racial attitudes.

Conclusions

Implicit racial attitudes can take on a shared property at the community level and effectively explain racial disparities. COVID-19 cases are highest when both the percent of Black county residents and implicit racial attitudes are high.

OPEN ACCESS

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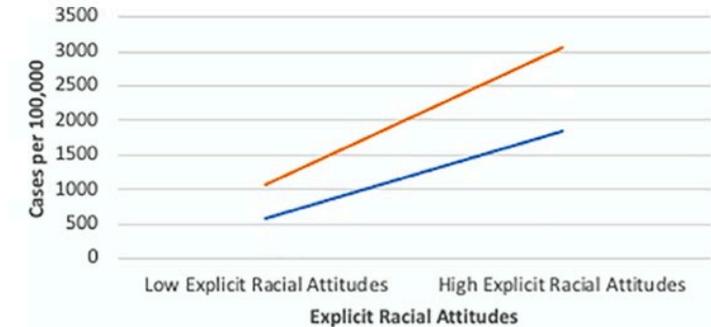
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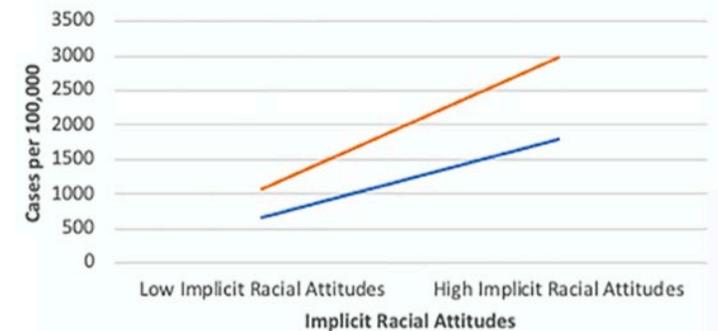
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Competing interests: The authors have declared that no competing interests exist.



A. Explicit Racial Attitudes



B. Implicit Racial Attitudes

Fig 1. Relationships among percent black county residents, explicit racial attitudes, implicit racial attitudes, and COVID-19 cases per 100,000 residents for January 22, 2020 to August 31, 2020. A. Explicit racial attitudes. B. Implicit racial attitudes.

Latino life expectancy will decrease due to COVID-19

The Disproportionate Impact of COVID-19 on Older Latino Mortality: The Rapidly Diminishing Latino Paradox

Rogelio Sáenz, PhD ✉, Marc A Garcia, PhD

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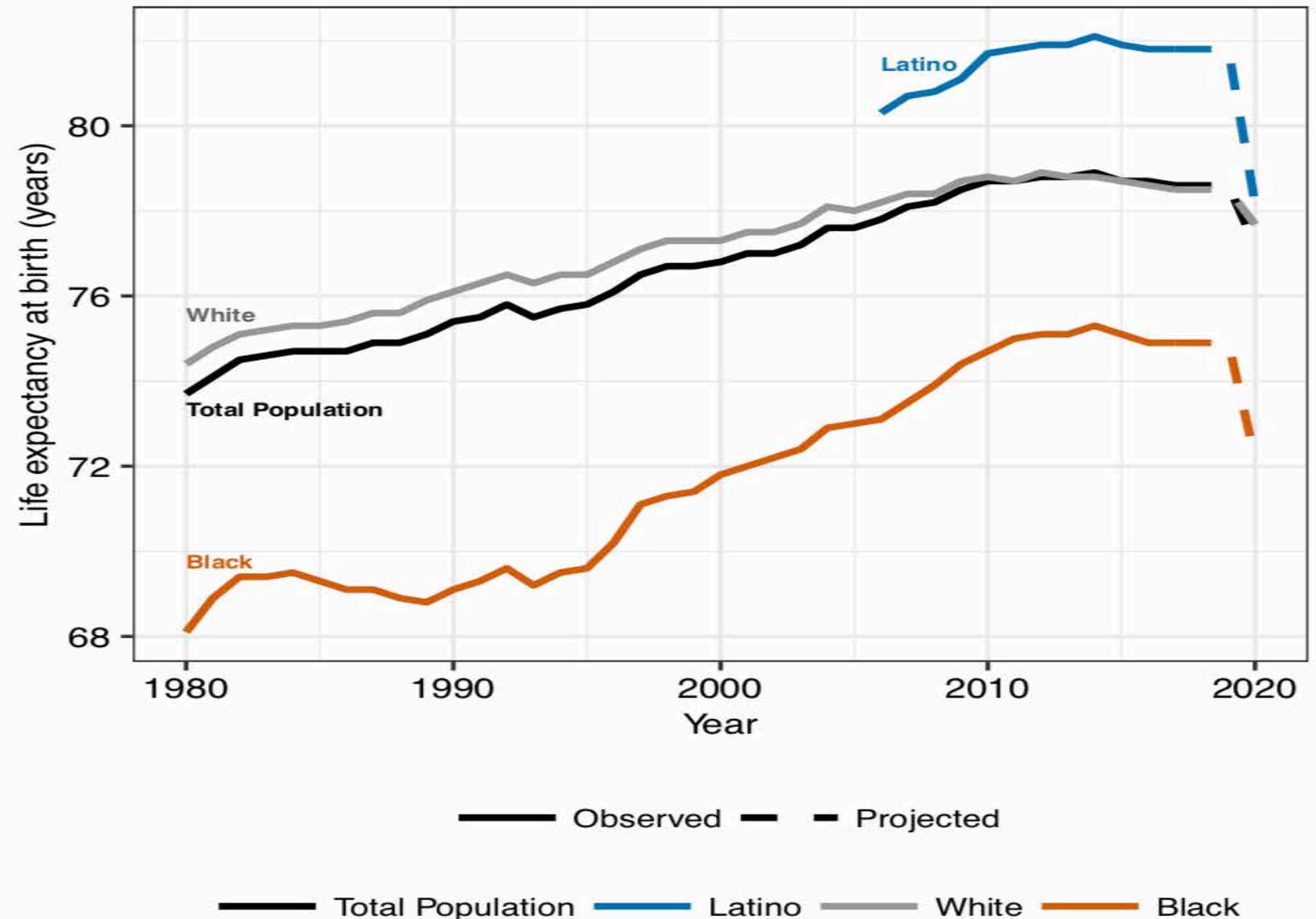
Abstract

Objectives

This brief report aims to highlight stark mortality disparities among older Latinos that result from the novel coronavirus disease (COVID-19) pandemic.

Methods

We use recent data from the Centers for Disease Control and Prevention to compute age-specific death rates (ASDRs) for 3 causes of death: deaths from COVID-19, residual deaths, and total deaths for 4 age groups (55–64, 65–74, 75–84, and 85 and older) to assess the impact of COVID-19 on older Latino mortality relative to non-Latino Whites and non-Latino Blacks and also in comparison to residual deaths. Additionally, we obtain ASDRs for all causes of deaths from 1999 to 2018 to provide a pre-pandemic context and assess the extent to which the consistently observed mortality advantage among Latinos persists during the pandemic.



The costs of addressing COVID-19 Impact on ETE funding and timeline?



Dr. Tom Frieden @DrTomFrie... · Aug 19

Estimated cost of recent epidemics/pandemics:

SARS (2003) - \$40 billion
H5N1 (2006) - \$40 billion
H1N1 (2009) - \$45 billion
Ebola (2014) - \$55 billion
COVID-19 (2020) - \$8.8 TRILLION

Investing in public health preparedness is FAR cheaper than the economic impact of a pandemic.

7:00 AM · Aug 20, 2020 · Twitter for Android

VIEWPOINT

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Lawrence H. Summers, PhD
Harvard Kennedy School, Cambridge, Massachusetts.

Viewpoint pages 1491 and 1493 and Editorial pages 1502 and 1504

Related article page 1562

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jama.com

The COVID-19 Pandemic and the \$16 Trillion Virus

The SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2) pandemic is the greatest threat to prosperity and well-being the US has encountered since the Great Depression. This Viewpoint aggregates mortality, morbidity, mental health conditions, and direct economic losses to estimate the total cost of the pandemic in the US on the optimistic assumption that it will be substantially contained by the fall of 2021. These costs far exceed those associated with conventional recessions and the Iraq War, and are similar to those associated with global climate change. However, increased investment in testing and contact tracing could have economic benefits that are at least 30 times greater than the estimated costs of the investment in these approaches.

Since the onset of coronavirus disease 2019 (COVID-19) in March, 60 million claims have been filed for unemployment insurance. Before COVID-19, the greatest number of weekly new unemployment insurance claims (based on data from 1967 on) was 695 000 in the week of October 2, 1982. For 20 weeks beginning in late March 2020, new unemployment claims exceeded 1 million per week; as of September 20, new claims have been just below that amount.

The total cost [of the pandemic] is estimated at more than \$16 trillion, or approximately 90% of the annual gross domestic product of the US.

Recessions feed on themselves. Workers not at work have less to spend, and thus subsequent business revenue declines. The federal government offset much of the initial loss owing to the shutdown, which has averted what would likely have been a new Great Depression. But the virus is ongoing, and thus full recovery is not expected until well into the future. The Congressional Budget Office projects a total of \$7.6 trillion in lost output during the next decade.¹

Lower output is not the only economic cost of COVID-19; death and reduced quality of life also can be measured in economic terms. To date, approximately 200 000 deaths have been directly attributable to COVID-19, many more will doubtless occur. In the US, approximately 5000 COVID-19 deaths are occurring per week and the estimated effective reproduction number (R_t , [ie, the average number of people who become infected by a person with SARS-CoV-2 infection]) is approximately 1. If these rates continue, another 250 000 deaths can be expected in the next year. Seasonal factors could increase mortality, although whether COVID-19 will display a large seasonal pattern is unknown. In addition to COVID-19 deaths, studies suggest increased deaths from other causes, amounting to almost 40% of COVID-19-related deaths. Thus, if the current tra-

jectories continue, an estimated 625 000 cumulative deaths associated with the pandemic will occur through next year in the US.

Although putting a value on a given human life is impossible, economists have developed the technique of valuing "statistical lives"; that is, measuring how much it is worth to people to reduce their risk of mortality or morbidity. This approach has been used as a standard in US regulatory policy and in discussions of global health policy.²

There is a lengthy economic literature assessing the value of a statistical life; for example, in environmental and health regulation. Although no single number is universally accepted, ranges are often used. In environmental and health policy,³ for example, a statistical life is assumed to be worth \$10 million. With a more conservative value of \$7 million per life, the economic cost of premature deaths expected through the next year is estimated at \$4.4 trillion.

Some individuals who survive COVID-19 are likely to have significant long-term complications, including respiratory, cardiac, and mental health disorders, and may have an increased risk of premature death. Data from survivors of COVID-19 suggest that long-term impairment occurs for approximately one-third of survivors with severe or critical disease.⁴ Because there are approximately 7 times as many survivors from severe or critical COVID-19 disease as there are COVID-19 deaths, long-term impairment might affect more than twice as many people as the number of people who die.

Given the predominance of respiratory complications among COVID-19 survivors, affected individuals may be like those with moderate chronic obstructive pulmonary disease, which has been estimated to have a quality-of-life disability of approximately -0.25 to -0.35. Assuming a total reduction in quality-adjusted life expectancy, including length as well as quality of life, of 35% and taking into consideration the assumed value of a year of life yields an estimated loss from long-term complications of \$2.6 trillion for cases forecast through the next year.

Even individuals who do not develop COVID-19 are affected by the virus. Loss of life among friends and loved ones, fear of contracting the virus, concern about economic security, and the effects of isolation and loneliness have all taken a toll on the mental health of the population. The proportion of US adults who report symptoms of depression or anxiety has averaged approximately 40% since April 2020; the comparable figure in early 2019 was 11.0%.⁵ These data translate to an estimated 80 million additional individuals with these mental health conditions related to COVID-19. If, in line with prevailing estimates, the cost of these conditions is valued at about \$20 000 per person per year and the mental health symptoms

Possible ways forward

Medicaid expansion is gaining popularity

AP **AP NEWS**

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After victories, Medicaid expansion revisited in Mississippi

By LEAH WILLINGHAM August 30, 2020

JACKSON, Miss. (AP) — After voters expanded Medicaid in conservative states like Missouri and Oklahoma, health care advocates are renewing a push for expansion in Mississippi and other Southern states where Republican leaders have long been opposed.



They say the changing tide has followed rising income inequality, joblessness and pressure from hospitals in economic turmoil — issues exacerbated by the coronavirus pandemic.

“There have been, in the last two years, votes on Medicaid expansion in some of the most conservative, Republican-leaning states in the

States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession

FIGURE 4

Over 650,000 Uninsured Essential Workers Could Gain Medicaid Coverage if Holdout States Adopted Expansion



Note: “Essential workers” refers to essential or front-line workers likely required to go to work despite stay-at-home orders. Fifteen states have not implemented the Affordable Care Act’s option to expand their Medicaid program to cover low-income adults.

Source: CBPP analysis of Census Bureau data

COVID-19 and identification of people with acute HIV

AIDS and Behavior
<https://doi.org/10.1007/s10461-020-02899-x>

NOTES FROM THE FIELD

Routine Screening for HIV in an Urban Emergency Department During the COVID-19 Pandemic

Kimberly A. Stanford¹ · Eleanor E. Friedman² · Jessica Schmitt² · Thomas Spiegel¹ · Jessica P. Ridgway² · Michelle Moore² · Michelle Taylor² · David Pitrak² · Moira C. McNulty²

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The emergency department (ED) has been identified as a key location for HIV screening, with many new diagnoses resulting from non-targeted ED screening programs [1]. The COVID-19 pandemic has greatly affected ED operations across the country. Many EDs have seen dramatic increases in patient volumes, while others have experienced a lull, as only the most serious cases continue to arrive at the ED. Preparedness for and management of COVID-19 are clearly emergent public health priorities, but other important public health initiatives, such as expanded HIV screening and linkage to care, must continue. Routine HIV screening in the ED faces many barriers in normal times, due to competing priorities and complexities of implementation [2]. The COVID-19 pandemic presents further challenges to routine screening programs. We describe how our urban ED in Chicago, with advance planning, was able to continue routine HIV screening in the face of the COVID-19 pandemic.

HIV Screening Program and ED Design

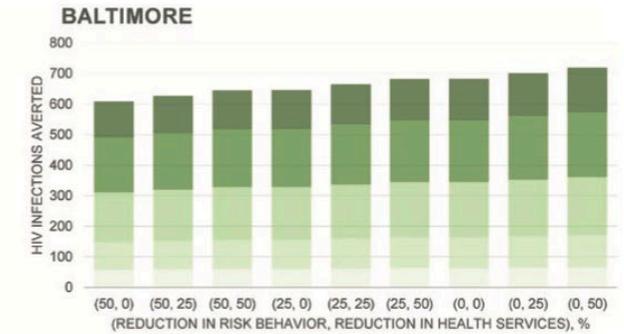
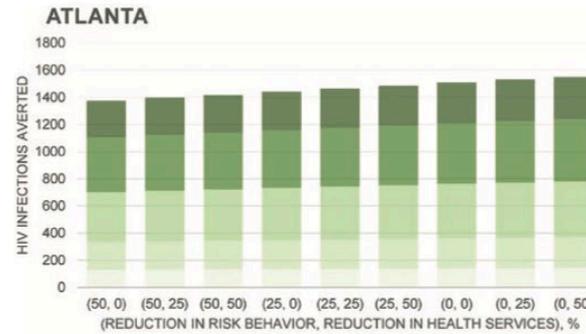
The University of Chicago has had a program for expanded HIV testing and linkage to care at our hospitals and clinics since 2011. Recently that program has placed special emphasis on screening in the ED, utilizing automated electronic medical record (EMR) reminders to support test ordering. All ED patients under age 65 who have no known diagnosis of HIV and have not been tested for HIV in the last year are eligible for screening. The HIV care team assumes all

Testing Trends

During the first month and a half of the COVID-19 pandemic, the ED conducted 1789 HIV tests, screening 20.8% of the total 8616 ED visits during this time. This was not significantly different from testing performed during the

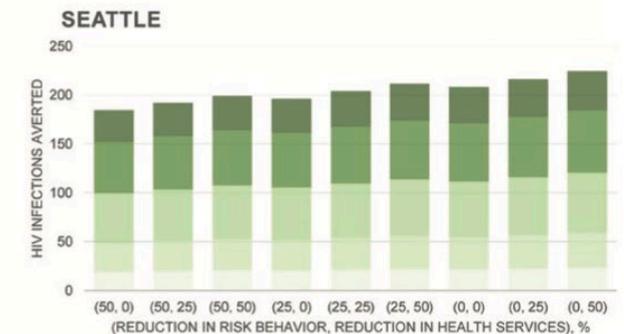
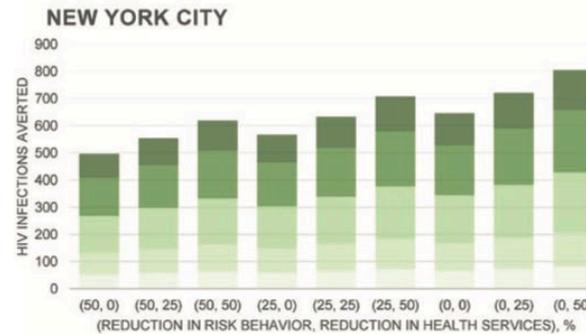
Increasing dx of acute HIV

- 6 to nearly 30 cases
- Primarily Black



Opt-out HIV testing with SARS-CoV-2 testing and contact tracing could reduce HIV infections between 2020–2025 in all 6 cities:

- As low as **576– 696** (1.6%–1.7%) fewer infections with 10% offered HIV testing (6.6% accepting a test)
- As high as **5840–7225** (16.3%–17.2%) fewer infections with 90% offered testing (59.3% accepting a test)



LINKED OPT-OUT HIV TESTING LEVELS

10% 25% 50% 75% 90%

(Zang, et al 2020)

Contribution of algorithms/ guidelines to health inequities

The NEW ENGLAND JOURNAL of MEDICINE

MEDICINE AND SOCIETY

Debra Malina, Ph.D., Editor

Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

Darshali A. Vyas, M.D., Leo G. Eisenstein, M.D., and David S. Jones, M.D., Ph.D.

Physicians still lack consensus on the meaning of race. When the *Journal* took up the topic in 2003 with a debate about the role of race in medicine, one side argued that racial and ethnic categories reflected underlying population genetics and could be clinically useful.¹ Others held that any small benefit was outweighed by potential harms that arose from the long, rotten history of racism in medicine.² Weighing the two sides, the accompanying Perspective article concluded that though the concept of race was “fraught with sensitivities and fueled by past abuses and the potential for future abuses,” race-based medicine still had potential: “it seems unwise to abandon the practice of recording race when we have barely begun to understand the architecture of the human genome.”³

The next year, a randomized trial showed that a combination of hydralazine and isosorbide dinitrate reduced mortality due to heart failure among patients who identified themselves as black. The Food and Drug Administration granted a race-specific indication for that product, BiDil, in 2005.⁴ Even though BiDil’s ultimate commercial failure cast doubt on race-based medicine, it did not lay the approach to rest. Prominent geneticists have repeatedly called on physicians to take race seriously,^{5,6} while distinguished social scientists vehemently contest these calls.^{7,8}

Our understanding of race and human genetics has advanced considerably since 2003, yet these insights have not led to clear guidelines on the use of race in medicine. The result is ongoing conflict between the latest insights from population genetics and the clinical implementation of race. For example, despite mounting evidence that race is not a reliable proxy for genetic difference, the belief that it is has become embedded, sometimes insidiously, within medical practice. One

subtle insertion of race into medicine involves diagnostic algorithms and practice guidelines that adjust or “correct” their outputs on the basis of a patient’s race or ethnicity. Physicians use these algorithms to individualize risk assessment and guide clinical decisions. By embedding race into the basic data and decisions of health care, these algorithms propagate race-based medicine. Many of these race-adjusted algorithms guide decisions in ways that may direct more attention or resources to white patients than to members of racial and ethnic minorities.

To illustrate the potential dangers of such practices, we have compiled a partial list of race-adjusted algorithms (Table 1). We explore several of them in detail here. Given their potential to perpetuate or even amplify race-based health inequities, they merit thorough scrutiny.

CARDIOLOGY

The American Heart Association (AHA) Get with the Guidelines–Heart Failure Risk Score predicts the risk of death in patients admitted to the hospital.⁹ It assigns three additional points to any patient identified as “nonblack,” thereby categorizing all black patients as being at lower risk. The AHA does not provide a rationale for this adjustment. Clinicians are advised to use this risk score to guide decisions about referral to cardiology and allocation of health care resources. Since “black” is equated with lower risk, following the guidelines could direct care away from black patients. A 2019 study found that race may influence decisions in heart-failure management, with measurable consequences: black and Latinx patients who presented to a Boston emergency department with heart failure were less likely than white patients to be admitted to the cardiology service.²⁴

Opinion

VIEWPOINT

Addressing Systemic Racism Through Clinical Preventive Service Recommendations From the US Preventive Services Task Force

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Melissa Simon, MD
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Alex H. Krist, MD, MPH
Virginia Commonwealth University, Richmond.

Viewpoint
Supplemental content

Wellness and disease prevention are the foundations of health. The US Preventive Services Task Force (USPSTF) is congressionally mandated to make evidence-based recommendations about clinical preventive services, which, if delivered equitably to the intended population, can prevent many premature deaths. All USPSTF recommendations are based on a rigorous and objective methodology that has been continually refined since 1982. This methodology was cited by the Institute of Medicine as a gold standard for making guidelines.¹ In addition, the Patient Protection and Affordable Care Act mandated coverage of preventive services without cost sharing for USPs recommended clinical preventive services.

insurers without cost sharing for USPs recommended clinical preventive services.

However, when making recommendations, USPSTF often finds substantial data that saving benefits of recommended services are not equally available to Black, Indigenous, and other people of color. For instance, the 2020 system form modeling for the USPSTF colorectal cancer recommendation found consistent disparities across the screening-to-treatment continuum, with Black patients experiencing worse outcomes than White patients. This underscores the need to ensure consistent quality preventive and treatment services for all groups experiencing worse outcomes.

As described in the 2003 Institute of Medicine report *Unequal Treatment: Confronting Disparities in Health Care*, health inequities are a “historic context in which health care resources are differentially allocated on the basis of social, economic, and structural factors”² and are sustained by systemic racism. The USPSTF considers systemic racism to be a “historic context in which health care resources are differentially allocated on the basis of social, economic, and structural factors”² and are sustained by systemic racism. The USPSTF considers systemic racism to be a “historic context in which health care resources are differentially allocated on the basis of social, economic, and structural factors”² and are sustained by systemic racism.

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jama.com

The 2018 Quality and Disparities Report from the Agency for Healthcare Research and Quality, which included measures on healthy living (eg, receipt of smoking cessation counseling), patient-centeredness of care, care coordination (eg, for diabetes and asthma care), and effective treatment (eg, outcomes of cancer care), showed an improvement in the quality of health care from 2000 through 2017 on most, but not all, measures.⁴ Also, while there were some improvements, disparities persisted across many priority areas. Overall, compared with White people, Black people

“USPSTF is creating a roadmap that will be guided by a workgroup commissioned to develop and advance the USPSTF approach to how systemic racism affects preventive health care.”

ample, despite knowing for more than half a century that Black men are twice as likely to die from prostate cancer as White men, the US-based Prostate, Lung, Colorectal, and Ovarian Cancer screening trial included only 3370 Black men in its 76 683 study sample.

In some cases, the USPSTF has derived evidence to inform recommendations that may promote health equity. For example, a modeling study commissioned to inform an updated USPSTF lung cancer screening recommendation showed that initiating screening at a younger age and lower smoking intensity may improve life-years gained.⁸ Because Black men are at greater risk than White men for lung cancer at lower pack-years of smoking, lowering the pack-year level at which to start screening, as the USPSTF is now recommending, may reduce racial disparities in lung cancer health outcomes if

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Re-assess prevention/ care algorithms or guidelines

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New Algorithms Could Reduce Racial Disparities in Health Care

Machine learning programs trained with patients' own reports find problems that doctors miss—especially in Black people.

f t e



Annals of Epidemiology
journal homepage: www.annalsofepidemiology.org

Original article
Explaining racial disparities in HIV incidence in black and white men who have sex with men in Atlanta, GA: a prospective observational cohort study

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ABSTRACT
Purpose: To determine whether racial disparities in HIV incidence among men who have sex with men (MSM) were explained by differences in risk behaviors. Methods: In a longitudinal cohort study, 31 white and 23 black MSM were compared with an age- and sex-matched control group to understand media- and behavioral risk factors. Results: Thirty person-years (person-years [PY] interval [CI]: 4.2–36.4) were observed. Black MSM (10.1–13.6–6.4) times higher HIV incidence than white MSM. Conclusions: Racial disparities in HIV incidence among MSM are not explained by differences in risk behaviors. These findings therefore could not explore reasons for disparities [6]. How we think about reasons for black versus white disparities among U.S. MSM was elegantly framed by Millet et al. in 2006 [7]; this conceptual framework has guided the scientific agenda in the field for nearly a decade. We conducted a prospective, cohort study of black and white MSM in Atlanta that systematically measured the domains suggested by Millet et al. [7] to assess their potential

Introduction
Human immunodeficiency virus (HIV) epidemiology in the United States is driven by an unrelenting epidemic among men who have sex with men (MSM) [1,2] and is remarkable for black-white disparities in HIV among MSM [3] and for expanding epidemics among young black MSM. There is an emerging consensus that factors beyond individual risk behaviors (e.g.,

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http://dx.doi.org/10.1016/j.annepidem.2015.03.006
1047-2797/© 2015 Elsevier Inc. All rights reserved.

Of the 31 men who seroconverted and had behavioral data to assess PrEP eligibility:

- 22 (65%) met current PrEP eligibility guidelines at baseline assessment.
- 7 of 8 (88%) white men and 15 of 23 (65%) black men who seroconverted met PrEP eligibility guidelines

We can reduce health inequities

Reducing HIV-Related Health Disparities in the Health Resources and Services Administration's Ryan White HIV/AIDS Program

The Health Resources and Services Administration's Ryan White HIV/AIDS Program (RWHAP) supports direct health care treatment and support services to more than 50% of all people living with diagnosed HIV in the United States. A critical goal of the RWHAP is to reduce HIV-related health disparities to help end the HIV epidemic. From 2010 through 2016, the RWHAP made significant progress reducing viral suppression disparities among client populations, particularly among women, transgender persons, youths, Blacks or African Americans, and unstably housed clients.

To assist with the reduction of the remaining disparities in HIV-related health outcomes among clients, the RWHAP continues to support planning and resource allocation for RWHAP Parts A through D and AIDS Drug Assistance Program, as well as through implementing policy and program initiatives. Special Projects of National Significance, evaluation studies, and collaborations to disseminate effective interventions. (*Am J Public Health*. 2018;108:5246–5250. doi:10.2105/AJPH.2018.304689)

Paul Mandager, MSPH, Allison Marier, PhD, Stacy Cohen, MPH, Miranda Fanning, MPH, Heather Hawk, MSW, LICSW, and Laura W. Cheever, MD, ScM

The Ryan White HIV/AIDS Program (RWHAP), administered by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau, supports direct health care and support services for more than half a million people living with HIV (PLWH)—more than 50% of all people living with diagnosed HIV in the United States.^{1,2} The RWHAP has successfully created effective patient-centered services to support strong provider-patient relationships. The RWHAP funds grants to cities or counties, states, and local community-based organizations to coordinate and deliver efficient and effective HIV care, treatment, medication, and support services for low-income PLWH. Since it was established, the RWHAP has developed a comprehensive system of safety-net providers to deliver these services. The RWHAP is critical to ensuring that PLWH are linked to and retained in care, are able to adhere to medication regimens, and remain virally suppressed. These goals are crucial not only to ensuring optimal HIV health outcomes among PLWH but also to preventing further transmission of the virus and, ultimately, ending the HIV epidemic.³

HRSA has focused on four goals to inform programmatic efforts and funding to end the HIV epidemic: (1) reduce the number of people who become infected with HIV, (2) increase

access to care and improve health outcomes for PLWH, (3) achieve a more coordinated national response to the HIV epidemic, and (4) reduce HIV-related health disparities.^{3,4} Essential to reducing HIV-related health disparities is the ability to monitor client-level health outcomes of PLWH served by the RWHAP. The RWHAP recipients and sub-recipients submit de-identified client-level data to HRSA through the RWHAP Services Report, including data to monitor progress toward achieving select indicators of HIV-related health outcomes,⁵ such as retention in HIV medical care and viral suppression. Since 2010, client-level RWHAP Services Report data have been used to assess the demographics of clients receiving services, progress in HIV-related outcomes, and disparities in HIV-related outcomes.

This commentary outlines trends in addressing disparities in viral suppression rates among PLWH served by the RWHAP and its initiatives to enhance efforts to reduce disparities in HIV-related health outcomes among key populations.

RWHAP DATA

We used data from the RWHAP Services Report, HRSA's primary source of annual, client-level data reported by more than 2000 funded grant recipients and subrecipients. These data have been reported since 2010, and HRSA has used these data to assess the demographics of clients receiving services through the RWHAP and their HIV-related outcomes. We used data from the 2010 and 2016 calendar-year RWHAP Services Report data sets. HRSA calculates viral suppression rates for PLWH who had had at least one outpatient ambulatory health service visit and had at least one viral load test reported during the calendar year; HRSA defines clients as virally suppressed if their most recent viral load test result within the calendar year was fewer than 200 copies per milliliter.

SELECT RWHAP CLIENT DEMOGRAPHICS

In 2016, the RWHAP served slightly more than 551 500 clients. Nearly two thirds (62.8%) of

ABOUT THE AUTHORS

All authors are with the HIV/AIDS Bureau, Health Resources and Services Administration, Rockville, MD. Correspondence should be sent to Paul Mandager, 5600 Fishers Lane, Rockville, MD 20852 (e-mail: pmandager@hrsa.gov). Reprints can be ordered at <http://www.ajph.org> by clicking the "Reprints" link. This article was accepted July 25, 2018. doi:10.2105/AJPH.2018.304689

TABLE 2—Ryan White HIV/AIDS Program Client Disparities in Viral Suppression: United States, 2010 and 2016

	Percentage Point Difference in Viral Suppression, 2010	Percentage Point Difference in Viral Suppression, 2016	Percentage Point Change in Difference, 2010–2016
Gender (Ref = male)			
Female	4.6	1.4	-3.2
Transgender	9.4	6.0	-3.4
Race/ethnicity (Ref = White)			
American Indian/Alaska Native	5.9	6.4	0.5
Asian	-2.5	-2.9	-0.4
Black/African American	13.0	8.1	-4.9
American Hispanic/Latino	2.7	2.2	-0.5
Multiple races	5.9	6.5	0.6
Native Hawaiian/Pacific Islander	5.8	4.6	-1.2
Age, y (Ref = 55–64)			
< 13	7.3	5.9	-1.4
13–24	32.5	19.5	-13.0
25–34	20.5	13.0	-7.5
35–44	9.9	7.7	-2.2
45–54	5.0	3.2	-1.8
≥ 65	-4.5	-3.3	1.2
Housing status (Ref = stable housing)			
Temporary	7.5	7.2	-0.3
Unstable	16.4	14.1	-2.3

Covid-19 by Race and Ethnicity: A National Cohort Study of 6 Million United States Veterans

Christopher T. Rentsch^{1,2}, Farah Kidwai-Khan^{1,3*}, Janet P. Tate^{1,3*}, Lesley S. Park^{4*}, Joseph T. King, Jr.^{1,5*}, Melissa Skanderson^{1*}, Ronald G. Hauser^{1,6}, Anna Schultze², Christopher I. Jarvis², Mark Holodny^{7,8}, Vincent Lo Re III⁹, Kathleen M. Akgün^{1,3}, Kristina Crothers¹⁰, Tamar H. Taddei^{1,3}, Matthew S. Freiberg^{11,12}, and Amy C. Justice^{1,3,13}

Abstract

Background: There is growing concern that racial and ethnic minority communities around the world are experiencing a disproportionate burden of morbidity and mortality from symptomatic SARS-Cov-2 infection or coronavirus disease 2019 (Covid-19). Most studies investigating racial and ethnic disparities to date have focused on hospitalized patients or have not characterized who received testing or those who tested positive for Covid-19.

Objective: To compare patterns of testing and test results for coronavirus 2019 (Covid-19) and subsequent mortality by race and ethnicity in the largest integrated healthcare system in the United States.

Results: Among all individuals in care, 74% were non-Hispanic white (white), 19% non-Hispanic black (black), and 7% Hispanic. Compared with white individuals, black and Hispanic individuals were more likely to be tested for Covid-19 (tests per 1000: white=9.0, [95% CI 8.9 to 9.1]; black=16.4, [16.2 to 16.7]; and Hispanic=12.2, [11.9 to 12.5]). While individuals from minority backgrounds were more likely to test positive (black vs white: OR 1.96, 95% CI 1.81 to 2.12; Hispanic vs white: OR 1.73, 95% CI 1.53 to 1.96), 30-day mortality did not differ by race/ethnicity (black vs white: OR 0.93, 95% CI 0.64 to 1.33; Hispanic vs white: OR 1.07, 95% CI 0.61 to 1.87).

Conclusions: Black and Hispanic individuals are experiencing an excess burden of Covid-19 not entirely explained by underlying medical conditions or where they live or receive care. While there was no observed difference in mortality by race or ethnicity, our findings may underestimate risk in the broader US population as health disparities tend to be reduced in VA.

		Transmission rate*	Transmission rate ratio (black vs white)	Incidence rate†	Incidence rate ratio (black vs white)	
Scenario 1: observed continuum (for each race)						
White MSM	9710	3.99	..	0.32
Black MSM	9833	5.45	1.36	2.57	7.92	.. ←
Black MSM receiving interventions in HIV care continuum‡						
Scenario 2: racially equivalent care	7206	3.99	1.00	1.89	5.80	-27%
Scenario 3: 95% diagnosis	7209	3.99	1.00	1.89	5.81	-27%
Scenario 4: 95% retention	7362	4.08	1.02	1.93	5.93	-25%
Scenario 5: concurrent 95% diagnosis and 95% retention	4066	2.25	0.56	1.06	3.28	-59%

(Rosenberg, 2014)

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(Rosenberg, 2014)

COVID-19 and Aging with HIV

COVID-19 Takes Aim at Aging Black Americans

Death rates per 100,000 U.S. population by age, race and Hispanic origin

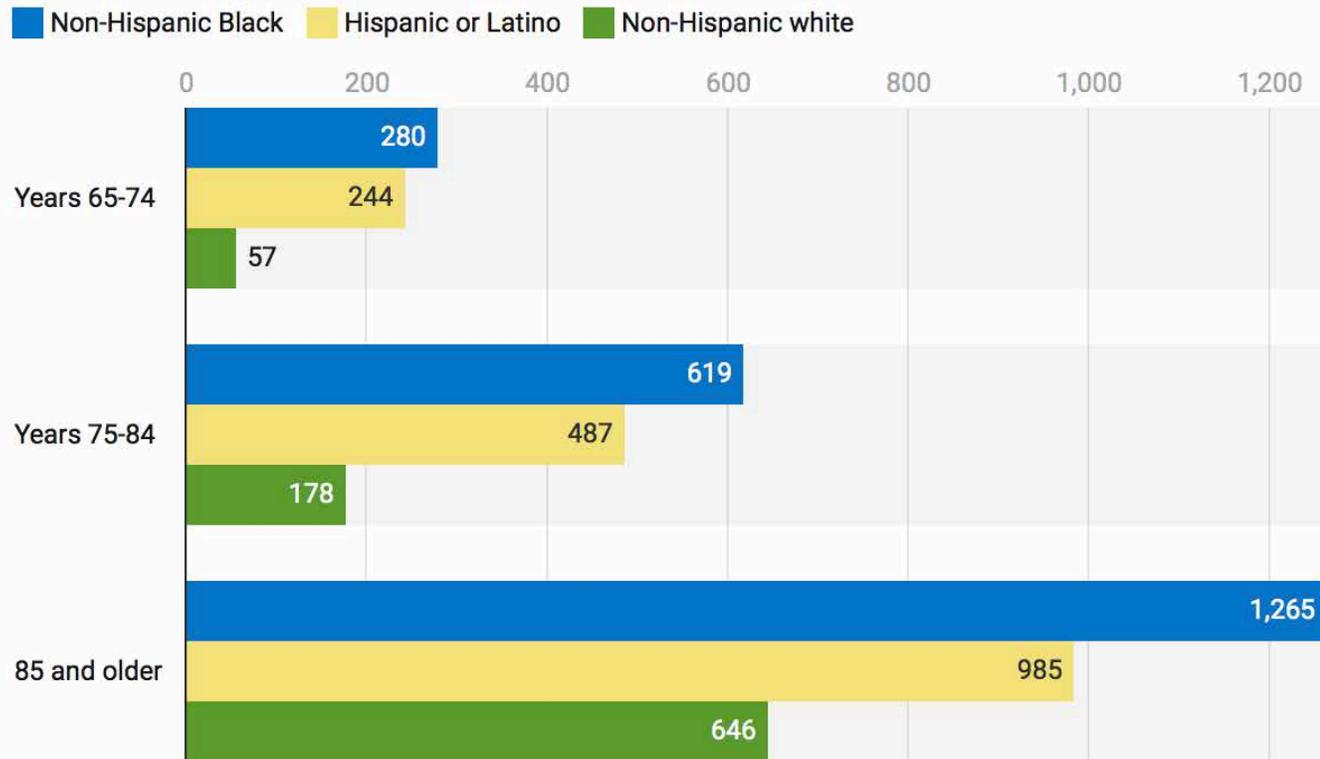


Chart by Elizabeth Lucas and Lydia Zuraw/Kaiser Health News

Source: KHN analysis of Centers for Disease Control and Prevention data from the week ending Feb. 1 through the week ending Aug. 8.

• [Embed](#)



Addressing differences in care long-term care facilities by income and protecting PLWH

We must think ahead about long-acting agents access to reduce inequities

POZ



Istock

SCIENCE NEWS

Long-Acting Cabotegravir Is an Effective PrEP Option for Women

Cabotegravir injections and daily Truvada pills are both highly effective, but women may find it easier to use the long-acting regimen.

FDA approves first monthly injectable to treat HIV infection

By ED SILVERMAN @Pharmalot
JANUARY 21, 2021
[Reprints](#)



Collaborations with other Federal Departments to reduce inequities

Income

- Working with DOL re: vocational training

Transportation

- Projects with DOT or with Uber/Lyft to help alleviate travel issues
- Establishing more healthcare facilities in communities of color

Housing

- Working with HUD re: PLWH in mixed income housing

Increasing healthcare access

- Medicaid work requirements
- Public charge rule

Solicit insight and recommendations from outside experts

Exercise convening power for a day-long meeting with an expert panel

- Academics
- Healthcare providers
- PWAs

Recommend activities under HHS purview

- Short-term/ long-term actions

Recommend activities outside HHS purview in conjunction with other agencies

- Short-term/ long-term actions

Declare Racism a Public Health Issue (What gets measured gets managed)

THE LANCET

Racism, the public health crisis we can no longer ignore

Extraordinary times call for extraordinary measures. We are facing a global pandemic, a climate catastrophe, an imminent recession, and possibly depression. The health of the most vulnerable and all of humanity is at stake. Yet there is nothing new, extraordinary, or unprecedented about racism, xenophobia, and discrimination. The killing of Mr George Floyd, on the back of numerous other deaths of Black Americans at the hands of the police,¹ and the two–four times increased mortality risk from COVID-19 for minority ethnic groups² have brought to light social and structural injustices that have existed for centuries and are derived from the same intersecting systems of oppression.

When a single act of violence is captured and amplified on social media, much like the televised US civil rights protests of the 1960s, it brings police brutality into the consciousness of people across the world. It elicits a visceral response, and humanity joins

they are based on race or ethnicity; in others, colour, caste, religious beliefs, Indigeneity or someone's migratory status. However, the underlying oppression that caused these injustices to occur are largely similar. Racism and xenophobia are about division and control, and ultimately power. Together they constitute a structural form of violence that results, at the extreme, in innocent people being murdered.

The COVID-19 outbreak has uncovered a crisis in our social and political fabric extending beyond the outbreak itself: an uncomfortable propensity towards racism, xenophobia, and intolerance exacerbated by transnational health challenges and national politics. Internationally, we have witnessed the vilification of particular nationalities, with overt forms of sinophobia.⁶ Politically, xenophobia has been weaponised to enforce border controls against particular nationalities and undermine migrant rights.⁷ In the UK, minoritised ethnic groups are more likely to contract a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and, subsequently, face a higher risk of a severe form of illness.

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Helping connect you with the NIH perspective, and helping connect us with yours

Posted on **March 1, 2021** by **Mike Lauer**

NIH Stands Against Structural Racism in Biomedical Research

I am proud to join my NIH colleagues today in reaffirming our commitment to fostering a diverse biomedical research workforce and

Dr. Michael Lauer is NIH's Deputy Director for Extramural Research, serving as the principal scientific leader and advisor to the NIH Director on the NIH extramural research program.

The New York Times

Declare Racism a Public Health Emergency

It would be more than just a symbolic gesture.

By Abdullah Shihpar
Mr. Shihpar is a public health impact initiatives advisor in the Department of Health and Human Services.

March 7, 2021

“A study published in August by amfAR, the Foundation for AIDS Research, found that predominately white counties had the lowest levels of coronavirus infection...high rates of illnesses among Black and Latinx people can be attributed in part to racist housing policies.”

Millett GA et al. *Journal of the International AIDS Society* 2020, **23**:e25639
<http://onlinelibrary.wiley.com/doi/10.1002/jia2.25639/full> | <https://doi.org/10.1002/jia2.25639>



COMMENTARY

New pathogen, same disparities: why COVID-19 and HIV remain prevalent in U.S. communities of colour and implications for ending the HIV epidemic

Gregorio A Millett

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(greg.millett@amfar.org)

Abstract

Introduction: The U.S. Ending the HIV Epidemic (EHE) Initiative was launched nationally in February 2019 to end the HIV epidemic by 2030. EHE initially scales up effective HIV prevention and treatment interventions to reduce HIV transmission in localities and populations at high risk for HIV. Eleven months into the EHE initiative, the first case of SARS-CoV-2 was diagnosed in the US [2]. Racial disparities in COVID-19 diagnoses and deaths became apparent soon after the first reported cases.

Discussion: One of the many common threads between HIV and COVID-19 is the disproportionate impact of these pathogens among communities of colour. A recent report by the National Academy of Sciences [3] states that HIV outcomes are due to health access, socio-economic factors and environmental conditions. Communities of colour, particularly Black and Brown communities, have re-emerged in epidemic proportions with COVID-19 cases, hospitalizations and deaths in communities of colour. Using data from the CDC, this commentary makes direct comparisons between HIV and COVID-19 racial disparities across the country. I examine three sets of challenges facing EHE: (1) Challenges that hamper both HIV and COVID-19 control efforts by insufficiently addressing the social determinants of health; amplification of disparities by COVID-19; (2) Challenges posed by COVID-19 (i.e. diverting HIV resources to address COVID-19 and (3) Challenges unrelated to COVID-19 (i.e. emergence of new and related health threats and long-term viability of EHE).

Conclusions: Racism and discrimination place communities of colour at greater risk for HIV and COVID-19. Sustaining an end to the U.S. HIV epidemic will require structural change to eliminate racial disparities.

Keywords: disparities; COVID-19; ending HIV epidemic; social determinants of health

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1 | INTRODUCTION

The United States (US) Ending the HIV Epidemic (EHE) Initiative was launched nationally in February 2019 [1]. The Initiative scales up proven prevention and treatment interventions to reduce HIV transmission in localities and populations at high risk for HIV. Eleven months into the EHE initiative, the first case of SARS-CoV-2 was diagnosed in the US [2]. Racial disparities in COVID-19 diagnoses and deaths became apparent soon after the first reported cases.

As early as mid-April, 2020, 22% of US counties with greater than a thirteen percent population of Black residents (the national average) accounted for 52% of COVID-19 diagnoses

and 57% of deaths nationwide [3]. As striking as these numbers are, the disproportionate impact of COVID-19 has not only affected Black communities. The Centers for Disease Control and Prevention (CDC) reported that American Indians were 3.5 times more likely to be diagnosed with COVID compared to Whites [4]. Another analysis found that 75% of COVID-19 'hot spot' counties were disproportionately Latinx [5], whereas a separate study reported disproportionate COVID-19 hospitalizations among people of colour across 12 states [6]. Although similar reports of racial disparities in COVID-19 infections have been reported in France [7], the United Kingdom [8], Canada [9] and Brazil [10], the issue has been covered more exhaustively in the scientific and grey literature in the US.



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COMMENTARY | Open Access |

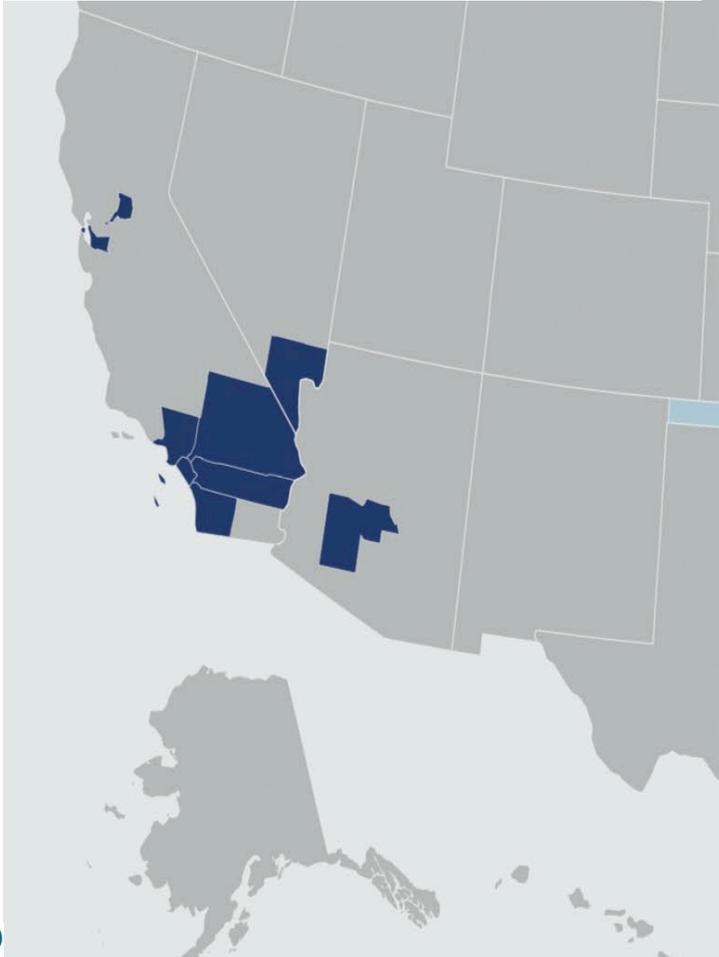
New Pathogen, Same Disparities: Why COVID-19 and HIV Remain Prevalent in U.S. Communities of Color and Implications for Ending the HIV Epidemic

Gregorio A. Millett

First published: 28 October 2020 | <https://doi.org/10.1002/jia2.25639>

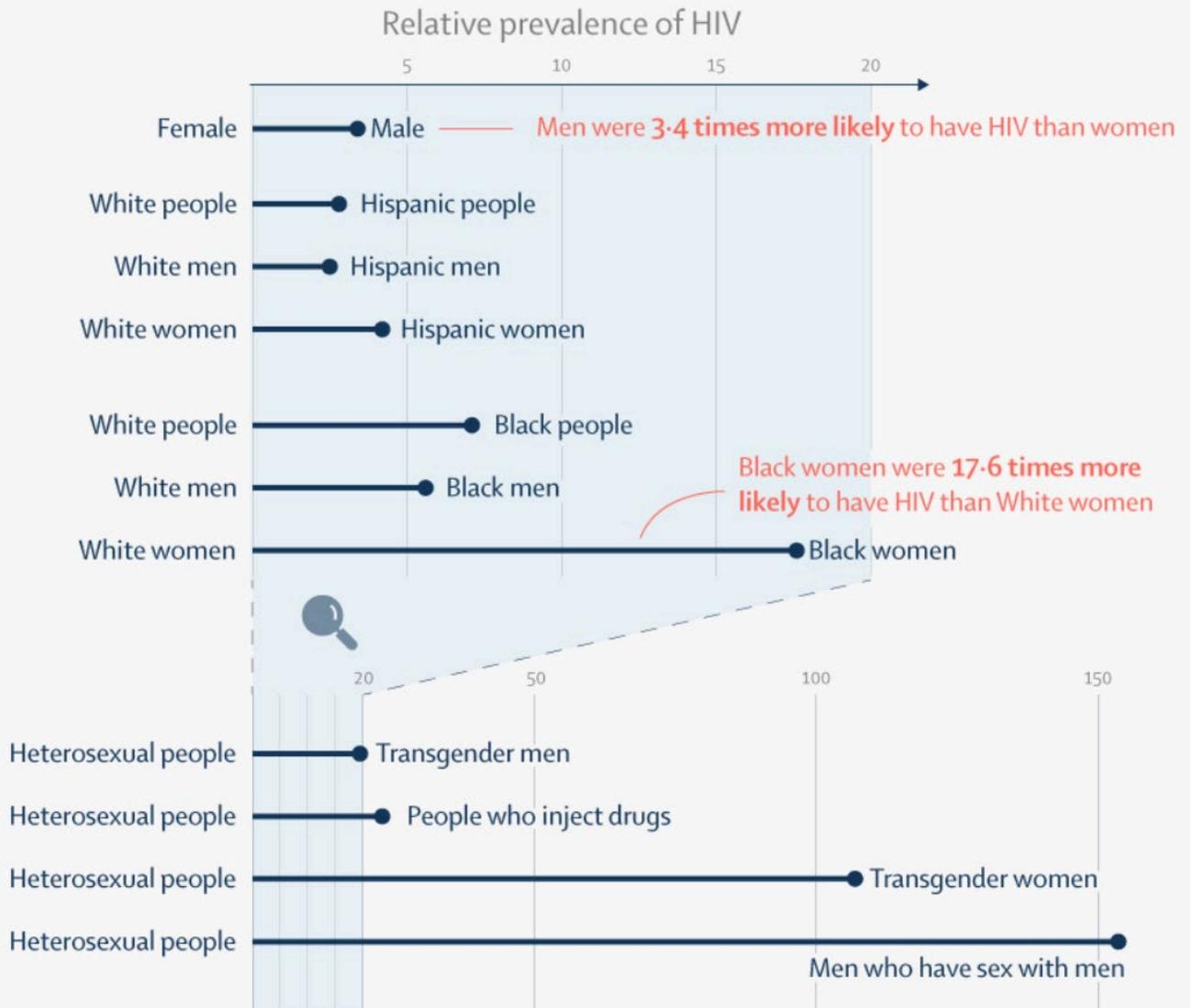


THE LANCET



Despite advances in HIV treatment and prevention, large inequalities still exist in the USA

Comparisons of HIV prevalence in the USA by race, sex, and risk group, 2017



Thank you.

Discussion