ACHIEVING HEALTH EQUITY

Breaking Barriers Summit 2019

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Centers for Disease Control and Prevention

January 23, 2019
PRESENTATION OVERVIEW

- Definitions: Health Equity, Health Disparities and Social Determinants of Health
- Epidemiology of HIV—United States and 6 Dependent Areas
  - State of the HIV Epidemic in the South
- Factors Driving the Southern HIV Epidemic
- CDC/DHAP Strategic Priorities and Initiatives to Achieve Health Equity
DEFINITION OF TERMS:

- Health Equity
- Health Disparities
- Social Determinants of Health
HEALTH EQUITY

- Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification.

- "Health equity" or “equity in health” implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

- Health - a state of complete physical, mental, and social well-being (WHO).
Healthy People 2020 defines a health disparity as “a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”
SOCIAL DETERMINANTS OF HEALTH

- Systems that influence health status.
- Shaped by distribution of money, power, and resources at global, national, and local levels.
- Gender, socioeconomic status, employment status, educational attainment, food security status, availability of housing and transportation, racism, and health system access and quality

http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf,
SOCIAL DETERMINANTS OF HEALTH

• Factors that are related to health outcomes
  – How a person develops during the first few years of life (early childhood development)
  – Immigration status
  – Stigma/Discrimination and social support
  – Language barriers
  – How much education a person obtains
  – Being able to get and keep a job
  – What kind of work a person does
  – Having food or being able to get food (food security)
  – Having access to health services and the quality of those services
  – Housing status (homelessness)
  – How much money a person earns

CDC works 24/7 to protect America from health, safety and security threats, both foreign and in the U.S.

NCHHSTP - Save lives, protect people, and reduce health disparities associated with HIV, viral hepatitis, STDs, and TB

DHAP - To improve quality of life and health equity by preventing HIV infections and reducing health disparities, HIV-related illnesses and deaths in the U.S.

DHAP OHE - to identify scientifically effective strategies to reduce disparities in rates of HIV between groups that are more or less advantaged socially and economically
DHAP Office of Health Equity – Organizational Chart

Donna Hubbard McCree, PhD, MPH, RPh
Associate Director for Health Equity

Postdoctoral Fellows
Erin Bradley, PhD, MPH
Angelica Geter, DrPH, MPH
Ashley Lima, PhD, MPH
Malendie Gaines, DrPH, MPH

Health Scientist
Vacant

Public Health Analyst
Vacant

Emilio German, MSHSA
Public Health Analyst
Hispanic/Latino Activities

Lamont Scales, MA
Public Health Analyst
MSM Coordinator

Established 09/06/2010
DHAP OFFICE OF HEALTH EQUITY

RESPONSIBILITIES AND STRATEGIC FOCUS

• **SCIENCE** – advance the science of health equity as it relates to addressing disparities in rates of HIV between groups who are more or less advantaged socially or economically

• **MONITORING** – monitor the Division’s progress on achieving the NHAS goals and NCHHSTP and DHAP goals per their Strategic Plans

• **PARTNERSHIP** – create partnerships that advance the science and assist in achieving the health equity goals of NHAS, NCHHSTP and DHAP.

• Coordinate the DHAP HIV Prevention in Communities of Color Postdoctoral Fellowship Program

• Maintain MAI Portfolio
EPIDEMIOLOGY OF HIV—UNITED STATES AND 6 DEPENDENT AREAS
Adults and Adolescents Living with Diagnosed HIV Infection, by Sex and Transmission Category, Year-end 2016—United States and 6 Dependent Areas

Note. Data have been statistically adjusted to account for missing transmission category. “Other” transmission category not displayed as it comprises 1% or less of cases.

- Male: N = 766,385
  - Male-to-male sexual contact: 71%
  - Heterosexual contact: 10%
  - Injection drug use (IDU): 10%
  - Male-to-male sexual contact & IDU: 7%
  - Perinatal: 1%

- Female: N = 240,306
  - Heterosexual contact: 76%
  - Injection drug use (IDU): 21%
  - Perinatal: 2%

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Note: Data have been statistically adjusted to account for missing transmission category. “Other” transmission category not displayed as it comprises 1% or less of cases.

a Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

b Perinatal includes persons whose infections were attributed to perinatal transmission, but were aged 13 years and older at the end of 2016.
Diagnoses of HIV Infection and Population by Race/Ethnicity
2017—United States

- American Indian/Alaska Native: 1% Population, 1% Diagnoses
- Asian: 3% Population, 6% Diagnoses
- Black/African American: 13% Population, 44% Diagnoses
- Hispanic/Latino: <1% Population, 18% Diagnoses
- Native Hawaiian/Other Pacific Islander: <1% Population, <1% Diagnoses
- White: 26% Population, 61% Diagnoses
- Multiple races: 2% Population, 2% Diagnoses

Note. Data for the year 2017 are considered preliminary and based on 6 months reporting delay.

*Hispanics/Latinos can be of any race.*

Population, United States (%): N = 325,719,178
Diagnoses of HIV Infection (%): N = 38,281
Diagnosed HIV Infections Attributed to Male-to-Male Sexual Contact by Race/Ethnicity, 2017—United States and 6 Dependent Areas

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>125</td>
<td>0.5</td>
</tr>
<tr>
<td>Asian</td>
<td>750</td>
<td>2.9</td>
</tr>
<tr>
<td>Black/African American</td>
<td>9,807</td>
<td>38.1</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>7,436</td>
<td>28.9</td>
</tr>
<tr>
<td>Native Hawaiian/other Pacific Islander</td>
<td>39</td>
<td>0.2</td>
</tr>
<tr>
<td>White</td>
<td>6,982</td>
<td>27.1</td>
</tr>
<tr>
<td>Multiple races</td>
<td>609</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>25,748</td>
<td>100</td>
</tr>
</tbody>
</table>

*Note. Data for the year 2017 are considered preliminary and based on 6 months reporting delay. Data have been statistically adjusted to account for missing transmission category.*

*a Hispanics/Latinos can be of any race.*

*b Because column totals for numbers were calculated independently of the values for the subpopulations, the values in each column may not sum to the column total.*
Diagnoses of HIV Infection among Adults and Adolescents, by Transmission Category, 2017—United States and 6 Dependent Areas

N = 38,640

Note. Data for the year 2017 are considered preliminary and based on 6 months reporting delay. Data have been statistically adjusted to account for missing transmission category. "Other" transmission category not displayed as it comprises less than 1% of cases.

*a Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.

- Male-to-male sexual contact: 67%
- Heterosexual contact—Female: 16%
- Heterosexual contact—Male: 7%
- Injection drug use (IDU)—Female: 3%
- Injection drug use—Male: 4%
- Male-to-male sexual contact and IDU: 3%
Diagnoses of HIV Infection among Male Adults and Adolescents, by Transmission Category, 2010–2016—United States and 6 Dependent Areas

Note. Data have been statistically adjusted to account for missing transmission category. “Other” transmission category not displayed as it comprises less than 1% of cases.

* Heterosexual contact with a person known to have, or to be at high risk for, HIV infection.
Diagnoses of HIV Infection among Men Who Have Sex with Men by Age at Diagnosis, 2010–2016—United States and 6 Dependent Areas

Note: Data have been statistically adjusted to account for missing transmission category. Data on men who have sex with men do not include men with HIV infection attributed to male-to-male sexual contact and injection drug use.
Diagnoses of HIV Infection among Men Who Have Sex with Men, by Age Group and Race/Ethnicity, 2017—United States and 6 Dependent Areas

Note: Data for the year 2017 are preliminary and based on 6 months reporting delay.

*Hispanics/Latinos can be of any race.
Diagnoses of HIV Infection among Men Who Have Sex with Men, by Region of Residence and Race/Ethnicity, 2017—United States and 6 Dependent Areas

Note. Data for the year 2017 are preliminary and based on 6 months reporting delay. Data have been statistically adjusted to account for missing transmission category. Data on men who have sex with men do not include men with HIV infection attributed to male-to-male sexual contact and injection drug use. Numbers less than 12, and trends based on these numbers, should be interpreted with caution.

Hispanics/Latinos can be of any race.
## Deaths of Persons with Diagnosed HIV Infection by Race/Ethnicity, 2016—United States

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>No.</th>
<th>Rate</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaska Native</td>
<td>46</td>
<td>1.9</td>
<td>0.3</td>
</tr>
<tr>
<td>Asian(^a)</td>
<td>95</td>
<td>0.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Black/African American</td>
<td>6,795</td>
<td>16.9</td>
<td>44.0</td>
</tr>
<tr>
<td>Hispanic/Latino(^b)</td>
<td>2,497</td>
<td>4.3</td>
<td>16.2</td>
</tr>
<tr>
<td>Native Hawaiian/other Pacific Islander</td>
<td>12</td>
<td>2.1</td>
<td>&lt;1</td>
</tr>
<tr>
<td>White</td>
<td>5,038</td>
<td>2.5</td>
<td>32.7</td>
</tr>
<tr>
<td>Multiple races(^c)</td>
<td>944</td>
<td>14.0</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Total(^c)</strong></td>
<td><strong>15,428</strong></td>
<td><strong>4.8</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

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*Note. Deaths of persons with diagnosed HIV infection may be due to any cause. Rates are per 100,000 population.\
\(^a\) Includes Asian/Pacific Islander legacy cases.\
\(^b\) Hispanics/Latinos can be of any race.\
\(^c\) Includes one person whose race/ethnicity is unknown.*
STATE OF THE HIV EPIDEMIC IN THE SOUTH
Southern states account for 38% of the US population but bear the highest burden of HIV infection.

* 2014 data
Diagnoses of HIV Infection among Adults and Adolescents by Region and Race/Ethnicity, 2017—United States

Note. Data for the year 2017 are considered preliminary and based on 6 months reporting delay.

-a Hispanics/Latinos can be of any race.
Stage 3 (AIDS) Classifications among Men Who Have Sex with Men, by Region of Residence and Race/Ethnicity, 2017—United States and 6 Dependent Areas

Note. Data for the year 2017 are preliminary and based on 6 months reporting delay. Data have been statistically adjusted to account for missing transmission category. Data on men who have sex with men do not include men with HIV infection attributed to male-to-male sexual contact and injection drug use.

* Hispanics/Latinos can be of any race
Rates of Adults and Adolescents Living with Diagnosed HIV Infection
Year-end 2016—United States and 6 Dependent Areas

N = 1,006,691  Total Rate = 367.6

Note. Data are based on address of residence as of December 31, 2016 (i.e., most recent known address).
Factors Driving the Southern HIV Epidemic
FACTORS RELATED TO HEALTH OUTCOMES

Social Determinants of Health

- How a person develops during the first few years of life (early childhood development)
- Immigration status
- Stigma/Discrimination and social support
- Language barriers
- How much education a person obtains
- Being able to get and keep a job
- What kind of work a person does
- Having food or being able to get food (food security)
- Having access to health services and the quality of those services
- Housing status (homelessness)
- How much money a person earns

CDC/DHAP STRATEGIC PRIORITIES AND ACTIVITIES TO ACHIEVE HEALTH EQUITY
DHAP Activities

- The Act Against AIDS initiative, which raises awareness about HIV through multiple campaigns and partnerships such as:
  - Let’s Stop HIV Together
  - Doing It
  - Start Talking. Stop HIV.
  - PS15-1505: Enhancing HIV Prevention Communication and Mobilization Efforts Through Strategic Partnerships
DHAP Activities: Health and Health Care

- PS15-1506: Health Department Demonstration Projects to Reduce HIV Infections and Improve Engagement in HIV Medical Care among MSM and Transgender Persons

- PS15-1509: Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for MSM of Color at Risk for and Living with HIV Infection

- PS15-1510: Health Department Demonstration Projects for Comprehensive Prevention, Care, Behavioral Health, and Social Services for MSM of Color at Risk for and Living with HIV Infection

- Partnerships for Care (P4C) (SMAIF) : Health Departments and Health Centers Collaborating to Improve HIV Health Outcomes
DHAP Activities: Built Environment

- PS11-003: Minority AIDS Research Initiative
- DHAP/ORISE HIV Prevention in Communities of Color Post-doctoral Fellowship Program
DHAP Strategic Plan Aligned with NHAS

Overarching Strategic Goals

1. Reduce New Infections
2. Increase Access to Care and Improve Health Outcomes for People Living with HIV
3. Reduce HIV-Related Health Disparities and Health Inequities

DHAP’s blueprint for achieving its vision of a future free of HIV

The three overarching goals highlighted in this plan are to decrease:

- incidence of infection
- morbidity and mortality and
- health disparities

Vision, National HIV/AIDS Strategy

“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.”

https://www.aids.gov/federal-resources/national-hiv-aids-strategy/overview/
DHAP STRATEGIC PLAN—GOAL 3: REDUCE HIV-RELATED DISPARITIES AND HEALTH INEQUITIES — HOW?

To work towards reducing HIV-related disparities and health inequities, DHAP will prioritize the following prevention efforts:

– Collecting and reporting data on HIV-related disparities
– Developing interventions, partnerships, and communication efforts that increase capacity to effectively deliver critical services to disproportionately affected key populations
– Addressing the social and structural factors that can influence health outcomes
Goal 3: Reduce HIV-related disparities and health inequities – Who?

- DHAP will target efforts to address HIV-related health disparities to the following populations: MSM, especially young black and Hispanic/Latino MSM; persons who inject drugs; transgender persons; and persons living in the southern United States.
What is High-Impact Prevention?

- HIP is a public health approach to disease prevention in which cost-effective, proven, and scalable interventions are targeted to specific populations based on disease burden. It provides a strategy for using data to maximize the impact of available resources and interventions.
- The primary goals of HIP are to prevent the largest number of new infections, save life-years, and reduce disparities among populations. In this approach to disease prevention, resources are aligned with disease burden in geographic areas and within populations.
What Can We Do To Reduce HIV-Related Inequities

To reverse the trends among All MSM, we must (but not limited to):

- Increase awareness and support **HIV testing**
- Strengthen existing efforts that support **treatment as prevention (TasP)** and increase engagement in care **(viral load suppression)**
- Promote HIV prevention among at risk persons (MSM of all races and ethnicities)
  - **Increase PrEP uptake**
  - **Reduce risk behaviors**
- Understand regional epidemiological HIV profiles
What Can We Do To Reduce HIV-Related Inequities

Six focus areas for priority actions:

- research and surveillance,
- health communication,
- Health policy,
- prevention programs,
- capacity building, and
- partnerships.
Health Departments

• Ensure state and local health departments have the capacity to provide essential services
• Assist when an outbreak affects more than one state, or a state needs assistance with an outbreak.
• Provide technical expertise, advice, and support.

Community-Based Orgs.

• Protect the health of the local community
• Provide frontline services – screening, treatment, support
• Conduct surveillance
• Help set public health policy and priorities

CDC

• Provide voice and advocacy to the members of the community
• Participate in discussions on public health policy and priorities
• Provide frontline services
Bridging the Gap Requires Continued Partnerships

Working together to identify and address structural and perceived barriers to accessing care for people living with or at risk for HIV
Thank You

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For more information, contact CDC
1-800-CDC-INFO (232-4636)

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.