Reducing Disparities in STDs: *It's Not About Me*

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"Education is an admirable thing, but it is well to remember from time to time that nothing that is worth knowing can be taught."

Oscar Wilde (1854 – 1900)

"Given that most tasks and jobs in this world are not about understanding the structure of the universe, only the actions of other humans…"

Morton L. Kringelbach

Overview

- Burden of STD
- Test, Treat, and Vaccinate
- Broad factors as potential sources of health disparities
- Policy implications to reduce health disparities

STDs in the United States

- Sexually transmitted diseases (STDs) are a major public health challenge
- Substantial progress in preventing, diagnosing, and treating certain STDs in recent years

But

- CDC estimates that approximately 19 million new infections occur each year
  - almost half of them among young people ages 15 to 24
- In addition to the physical and psychological consequences of STDs, these diseases also exact an economic cost
  - Direct medical costs associated with STDs in the US are estimated at up to $15.3 billion annually

STDs and HIV

- Testing & treatment of STDs can be effective in preventing the spread of HIV
- Improved understanding of the relationship between STDs and HIV infection aids the development of effective HIV prevention programs
- Persons infected with STDs are at least two to five times more likely than uninfected persons to acquire HIV infection if they are exposed to the virus through sexual contact.
- Persons infected with HIV who have an STD are also more likely to transmit HIV through sexual contact than other HIV-infected persons.

US Chlamydia Rates by race/ethnicity 1998–2007

1,108,374 cases in ‘07

US Chlamydia Age- and sex-specific rates 2007

Rate (per 100,000 population)

Men	Age	Women
11.8	10-14	123.0
615.0	15-19	3004.7
932.9	20-24	2948.8
518.6	25-29	1184.5
246.8	30-34	460.5
129.9	35-39	188.1
71.4	40-44	76.5
32.3	45-54	28.5
10.1	55-64	8.0
2.7	65+	1.8
190.4	Total	544.8

Axis scale (both sides): 0, 650, 1300, 1950, 2600, 3250

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US Gonorrhea Rates by race/ethnicity 1998–2007

355,991 cases in ‘07

Gonorrhea — Age- and sex-specific rates: United States, 2007

Rate (per 100,000 population)

Men	Age	Women
5.9	10-14	33.1
286.0	15-19	647.9
450.1	20-24	614.5
305.1	25-29	287.1
181.5	30-34	125.2
119.5	35-39	60.5
86.6	40-44	30.8
50.2	45-54	12.1
17.7	55-64	3.0
4.0	65+	0.4
113.9	Total	123.8

Axis (Men): 750 600 450 300 150 0 — Axis (Women): 0 150 300 450 600 750

US Primary & secondary Syphilis Rates by race/ethnicity 1998–2007

11,466 cases in ‘07

Primary and secondary syphilis — Age- and sex-specific rates: United States, 2007

Men

Rate (per 100,000 population)

Women

Men	Age	Women
0.0	10-14	0.1
3.8	15-19	2.4
13.4	20-24	3.5
14.9	25-29	2.6
13.1	30-34	2.0
14.4	35-39	1.8
13.9	40-44	1.7
6.9	45-54	0.9
2.5	55-64	0.2
0.5	65+	0.0
6.6	Total	1.1

US Primary & secondary syphilis Rates among 15- to 19-year-old males by race/ethnicity, 1998–2007

Primary & secondary syphilis % of reported cases* by sexual orientation & selected reporting sources, 2007

*21% of reported male cases with P&S syphilis cases were missing sex of sex partner information; 3.3% of reported male cases with sex of partner data were missing source of information data.
†MSM denotes men who have sex with men.

2007 Chlamydia, Gonorrhea, & P&S Syphilis Cases

1,200,000
1,000,000
800,000
600,000
400,000
200,000
0

1,108,374
524,791
355,991
250,245
11,466
5273

Chlamydia
Gonorrhea
Syphilis

US
AA Men
AA Women

Test, Treat, and Vaccinate

- Most public health clinics can routinely test for:
  - Chlamydia, gonorrhea, HIV, and syphilis
- Most public health clinics can effectively treat:
  - Chlamydia, gonorrhea, and syphilis
- Vaccine is only available for:
  - Genital human papillomavirus (HPV)

Three Broad Factors as Potential Sources of disparities

- Social Determinants
  - Racial inequality
  - Low educational attainment
  - Socioeconomic status
- Access Issues
  - High levels of uninsured
  - Lack of adequate health care w/in the community
  - Long wait times to be seen by a provider

Three Broad Factors as Potential Sources of disparities

- Health Care System
  - Cultural incompetence
  - High distrust among communities of color
  - Lower referral rates to support and specialized services (e.g. drug treatment, and housing assistance)

Policy Implications to reduce STD disparities

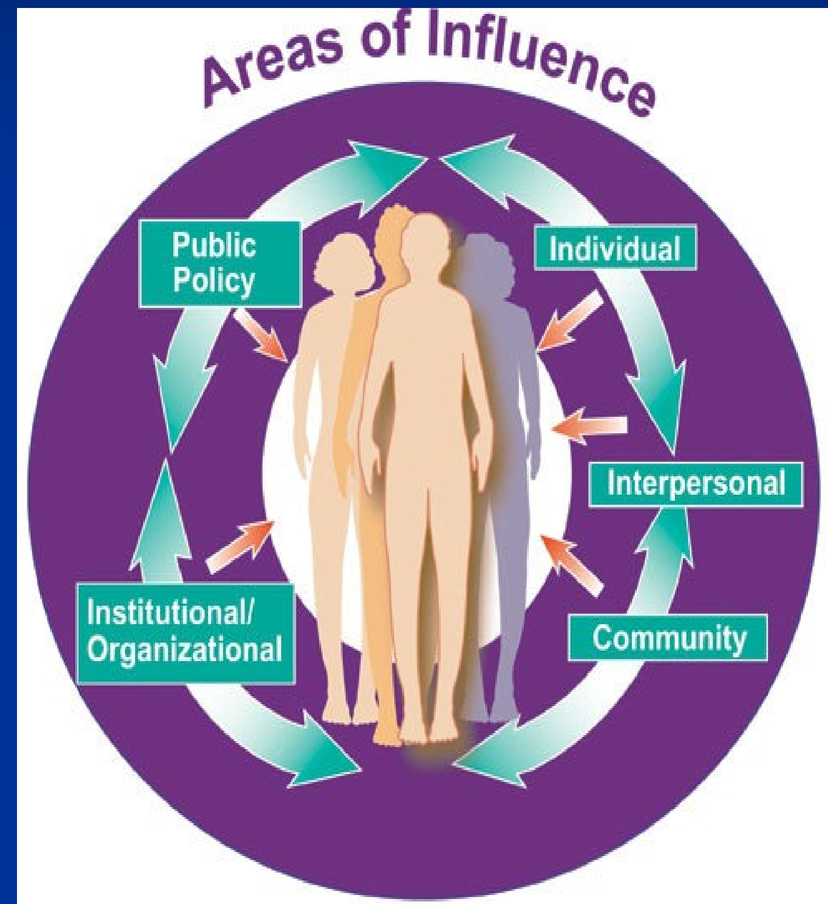
- Individual-level interventions
  - Use community members to craft culturally specific messages
  - Promote Community-based Health Care Planning
  - Promote patient education and literacy
- Access Interventions
  - Hire “patient navigators” who are trained to navigate patients through health care organizations
  - Engage affected communities to be screened for chlamydia and gonorrhea
  - Support routine STD screening services for persons seen in community health centers

Policy Implications to reduce STD disparities

- Health care Interventions
  - Collect & monitor data on disparities
  - Publicly report data
  - Train nurses and physicians to effectively engage and care for diverse populations through the adoption of cultural & linguistic standards
  - Encourage Attention to Disparities in Quality Improvement

Community Involvement & Partnerships

- Acknowledgement & response to the effects of racism, poverty, & other social issues on the persistence of syphilis
- Development & maintenance of partnerships to increase access to prevention & care services
- Assurance that affected communities are collaborative partners in developing, delivering, & evaluating interventions



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"In a sense , if one conceives of racism as a cell phone, the active malice is the ring tone on its highest volume, while passive indifference is the ring tone on vibrate. In either case, whether loudly or silently, the consequence is the same: a call is transmitted, a racial message is communicated."

Michael E. Dyson, *Come Hell or High Water: Hurricane Katrina and the Color of Disaster* (2006)

References

- Centers for Disease Control and Prevention. Sexually Transmitted Disease Surveillance, 2007. Atlanta, GA: U.S. Department of Health and Human Services; December 2008.
- Cohen, JA. Roundtable on Health Disparities. *Challenges and Successes in Reducing Health Disparities: Workshop Summary.* The National Academies Press, 2008, pg. 168 - 169.
- Smedley, BD. "*Addressing Racial and Ethnic Health Care Disparities*: Testimony to the House, Energy and Commerce Committee, Health Subcommittee." Joint Center for Political and Economic Studies. March 2009
- Wise, TJ. *Between Barack and a hard place: Racism and White denial in the age of Obama.* City Lights Books San Francisco. 2009, pg. 68.

References

- Sundra, DL. *Engaging Stakeholders in Evaluation: Strategies and Lessons Learned from CDC's Prevention Research Programs*. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP).
- Musa, D, Schulz, R, Harris, R, Silverman, M, and Thomas, SB. *Trust in the Health Care System and the Use of Preventive Health Services by Older Black and White Adults.* American Journal of Public Health, July 2009, Vol. 99, No. 7, pg. 1293 – 1299.
- Kringelbach, ML. *The Pleasure Center: Trust your Animal Instincts.* Oxford University Press, 2009, pg. 111 – 118.
- Fisher, TL, Burnet, DL, Huang, ES, Chin, MH, and Cagney, KA. Cultural Leverage: Interventions Using Culture to Narrow Racial Disparities in Health Care. Medical Care Research and Review, October 2007; 64(5 Suppl): 243S-282S.

For More Information About How You Can Get Involved Please Contact:

- Your Local Health Department
- CDC's Division of STD Prevention www.cdc.gov/std

  or me at dbj1@cdc.gov
- American Social Health Society www.ashastd.org

THANK YOU

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