The TB Challenge

"Partnering to Eliminate TB in African Americans"

A Newsletter from the Division of Tuberculosis Elimination, Field Services and Evaluation Branch

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Reported Tuberculosis and HIV-infection, 2005

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In this article, we discuss the need for improvements in HIV testing and reporting and potential populations who may most benefit from these improvements. More persons might accept HIV testing if rapid HIV diagnostics and opt-out testing were used. Prevention, early diagnosis, and access to care for both diseases are especially important for African-Americans, substance abusers, homeless persons, and inmates due to the high burden of both HIV and TB in these groups. Once HIV is diagnosed, TB can be prevented through targeted efforts to diagnose and treat latent TB infection before TB disease develops.

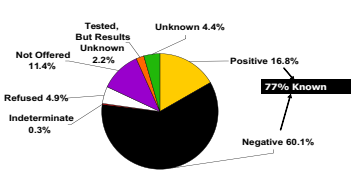
Globally, tuberculosis (TB) is the leading killer of people who are HIV-infected. In the United States, patients with TB disease and the human immunodeficiency virus (HIV) have over five times the odds of dying during anti-TB treatment and over three times the odds of being diagnosed with TB disease at death as HIV-uninfected patients. This underscores the importance of prevention, early diagnosis, and treatment for both TB and HIV. HIV is also the most important known risk factor for progression to TB disease from latent TB infection (LTBI). Two to eight percent of HIV-infected persons with LTBI progress to TB disease each year within 5 years after infection, versus a total of eight percent of HIV-uninfected persons with LTBI over a time period of 60 years. Highly active antiretroviral therapy (HAART) has been shown to reduce the risk of developing TB disease in HIV-infected persons, and reduces TB relapse and death in patients with TB disease. TB disease is an AIDS-defining opportunistic condition. If individuals are diagnosed with TB disease, provider knowledge of HIV infection and use of HIV medications is critical for optimal patient management and for referrals to care to prevent mortality and additional morbidities.

CDC has recommended HIV testing of all TB patients since 1989. Routine HIV testing has been recommended since 2001, since targeted testing based on provider assessment of patient risk behaviors fails to identify a substantial number of HIV-infected persons. This is because often the TB patients do not perceive themselves to be at risk for HIV or do not disclose their risks. Routine HIV testing of all TB patients can also reduce the stigma associated with testing. CDC's revised HIV testing guidelines issued in September 2006 call for "opt-out" HIV testing of all persons in clinic settings. Opt-out testing means that the provider should perform HIV testing after notifying the patient that: 1) the test will be performed, and 2) the patient may elect to decline or defer testing.

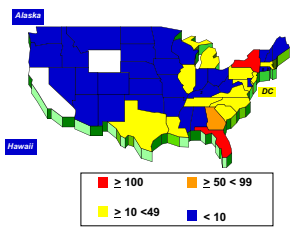
Our study objective was to describe the recent status of reported HIV infection in TB patients, HIV/TB comorbidity, and the characteristics of HIV/TB patients in the United States. We analyzed data reported for 2005 on HIV status from the National TB Surveillance System. California data were excluded because the state shares with CDC only the results of AIDS and TB registry matches. HIV-positive or HIV-negative status is defined as "known." HIV prevalence equal to or greater than one percent of any specific population is considered high.

In 2005, 69 percent of all TB patients had known HIV status. Of the remaining 31 percent, nearly half were not offered HIV testing and a quarter refused testing when offered. A greater percentage of non-Hispanic black TB patients had known HIV status (79 percent). For US-born non-Hispanic blacks, 77 percent had known HIV status. Black females were more likely than black males to have had unknown HIV status.

Reported HIV Status of Non-Hispanic US-born Black TB Patients U.S. Excluding California, 2005

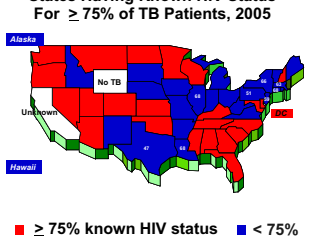


Number of Known Cases of HIV Infection Among Non-Hispanic Black TB Patients, 2005

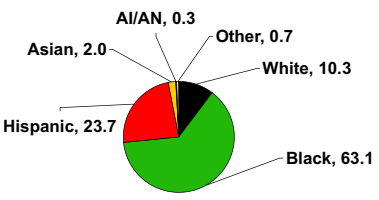


Black TB patients had the highest known prevalence of HIV infection of the major race/ethnic groups: 17% vs. 8% of Hispanics, 5% of whites, 2% of American Indian/Alaska Natives, and 1% of Asians. And, because of the high prevalence of both TB and HIV among blacks, nearly two-thirds (63%) of patients having both TB and HIV disease were black.

States Having Known HIV Status For ≥ 75% of TB Patients, 2005



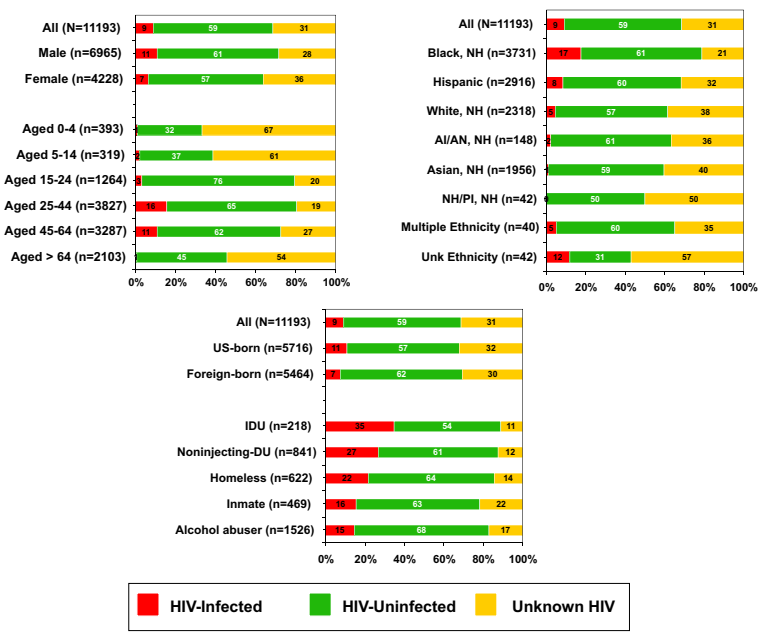
Composition of HIV/TB Patients, Excluding CA, 2005



The graphs below show reported data on the socio-demographics of TB patients by HIV status.

TB patients having exceptionally high (higher than the average 9%) rates of HIV-infection included males, those aged 25-44, those aged 45-64, non-Hispanic blacks, those of unknown race/ethnicity, US-born persons, injection drug users (IDUs), non-injection drug users, homeless persons, inmates, and alcohol abusers. Substance abuse, homelessness, and incarceration are factors associated with both HIV and TB incidence and transmission of disease.

Sociodemographics of TB Patients by HIV Status, U.S. Excluding California, 2005



Data updated through March 29, 2006.

In summary, nearly one-third of all TB patients and one-fifth of non-Hispanic black TB patients had unknown HIV status in 2005. HIV prevalence was high in nearly all TB patient groups, with some having exceptionally high HIV prevalence. Improvements in HIV testing and reporting are needed. The use of "opt-out" HIV testing and rapid HIV tests (with results available in < 20 minutes) may facilitate improvements in knowledge of HIV status. TB can be prevented through targeted efforts aimed at diagnosing and treating latent TB infection before TB disease develops, especially in substance abusers, homeless persons, and inmates. And, TB relapse and mortality may be avoided by early access to HIV care and support services. Because of the high burden of both HIV and TB in the African-American community, prevention, early diagnosis, and access to care are especially important for this population.

Eliminating Racial and Ethnic Health Disparities through Passion, Perseverance, and Public Health

Carmen J. Head, MPH, CHES, Director, School Health Programs, Society for Public Health Education

Carmen J. Head

The U.S. Public Health Service Syphilis Study at Tuskegee remains the most infamous biomedical research study conducted in this country. My grandfather, Fred Tyson, was among the poor uneducated sharecroppers included as study subjects. The painful, tragic, and unjust events that took place over the course of this 35 year study have left an irrevocable mark on clinical research. The study boldly highlights the history of unequal health practices in this country, and provides a clear example of how the abuse of power, and race and economic status can impact health. While we work to address disparities in health due to race and class, it is also important to examine the past and to discuss the root causes of health disparities. Not having a clear understanding of the past makes the creation of solutions for a brighter, healthier future unlikely.

This year marks the 10th anniversary of the Presidential apology made to the study survivors and their families. As we poignantly reflect upon the history of the study, we must continue to apply the lessons learned from Tuskegee with shared determination to identify the best practices and strategies in eliminating racial and ethnic health disparities. As both a family member of a syphilis study subject and public health professional, I am always eager to explore ways for us to transform the bleak legacy of the Syphilis Study into one that works toward improved health status for all --particularly the most disadvantaged.

In this short article, I share what I consider three important "must haves" in any planned approach or strategy to improving health outcomes for communities of color.

Passion

The elimination of racial and ethnic health disparities in this country calls for a devoted workforce of professionals from a number of fields that are impassioned about seeking social justice for the nation's racial and ethnic minorities. These professionals play a critical role in bringing about change through: shining the light on a growing need; identifying unethical practices; collecting health data and trends; framing and implementing public health policies; and implementing and evaluating programs aimed at improving health outcomes for all people. Many existing national, state, and local strategies that support efforts to eliminate racial and ethnic health disparities are due primarily to a cadre of concerned health advocates, researchers, and practitioners. These champions for health equity—many of whom themselves are minorities—strive to make a difference because of an undying passion that drives them to remain grounded in these efforts.

My choice to pursue public health as a profession is the direct result of my grandfather's involvement in the study. My passion for health equality and improved health status for African Americans, other minorities, and the economically challenged is a lifetime commitment.

While we are challenged each day in our current positions with issues or mundane obstacles that may be peripheral to our common goal of eliminating racial and ethnic health disparities, let us continue to see the broader picture of improved health for all communities. As we prepare the future public health workforce with the resources and skills needed to address health equity, let us instill in them the importance of working with conviction and purpose.

Perseverance

As we know, racial and ethnic disparities in health and health care are created and sustained by very broad and complex challenges, which have been in existence for hundreds of years. Often these complex challenges call for complex multi-level, multi-lingual, and multi-disciplinary strategies. Over the past 20 years, racial and ethnic health disparities have received much needed examination and resources, thanks in part to earlier reports like the Heckler report, and more recently, the Sullivan Commission and Unequal Treatment Report. Other research studies and reports have clearly identified a strong association between race, poverty, and health. More challenging for me to determine, however, is how to effectively reform social determinants such as education, employment, housing, and health care to improve the health status of minorities. CDC is making progress in addressing health disparities through projects like the CDC Racial & Ethnic Approaches to Community Health (REACH) and a project funded in select states by the CDC Division of Tuberculosis Elimination to reduce TB rates in the African-American community. However, much more work needs to be done.

Public Health

Public health research and practice play critical roles in working towards the elimination of racial and ethnic health disparities. Most national public health non-profit organizations have created resolutions to help guide their research, policy, and education efforts in addressing health disparities. Some organizations focus their efforts on encouraging policy makers to create sound public health policies. Other organizations strive to strengthen pre-professional public health programs, while still other non- profits use federal resources to engage communities in research to create and implement effective programs and services. The Society for Public Health Education (SOPHE), where I am currently employed, does all of the above. SOPHE's mission is to provide leadership to the profession of public health education and to contribute to the health of all people and the elimination of disparities through advances in health education theory and research, excellence in professional preparation and practice, and advocacy for public policies conducive to health. SOPHE has a longstanding commitment to racial and ethnic health disparities. Since 1967, SOPHE has embraced an Open Society that charges the organization to respect diversity and seek social justice and health equity for all. Since that time, SOPHE has engaged in multiple programs on the topic of health disparities and has secured federal and private funds for health disparities related programming.

In my current position at SOPHE, I manage two major dissemination activities for SOPHE's Health Education Research Agenda on Eliminating Racial and Ethnic Health Disparities. The first initiative involves the dissemination of an electronic resource that undergraduate and graduate programs in public health and health education can use in classroom discussion to address health disparities. Supported by funds from the National Cancer Institute, the contents of this DVD were created from presentations at SOPHE's 2005 Inaugural Health Education Research Disparities Summit entitled *Health Disparities and Social Inequities: Framing a Transdisciplinary Research Agenda in Health Education.* The second initiative, funded by the WK Kellogg Foundation, involves community dialogues that four local SOPHE chapters have received funding to convene. These community dialogues will provide National SOPHE community input for its research agenda.

SOPHE's commitment to advancing health equity is evidenced through its many other activities and partnerships sustained throughout the year. In March 2007, SOPHE partnered with members from the Coalition of National Health Education Organizations to hold the 10th Annual Health Education Advocacy Summit. At the summit, participants were trained on key policies and funding issues for federally funded health disparities initiatives. From October 31 through November 3, 2007, SOPHE hosted its 58th annual meeting. This year's meeting, *Partnerships to Achieve Health Equity*, took place in Alexandria, VA in collaboration with the CDC Racial & Ethnic Approaches to Community Health (REACH) project and Eta Sigma Gamma, a national professional health education honors society. To find out more information on SOPHE's resources or meetings, please contact the SOPHE office at 202-408-9804 or visit the Web site www.sophe.org.

Work towards the elimination of racial and ethnic health disparities will continue in many years to come; Dr. Martin Luther King once said "Of all the forms of inequality, injustice in health is the most shocking and inhumane." As we face a future nation that will become more racially and ethnically diverse, the health status of communities of color must be a top priority. Let us continue to work towards the dream of health equity and social justice for America and the global community. I would like to commend the work that CDC's Division of Tuberculosis Elimination has done and continues to do to address TB health disparities and I look forward to hearing about CDC's future successes.

Minority Health Resources:

Visit http://www.cdc.gov/omh/ to view announcements, upcoming conferences, meetings, trainings, reports, publications, and other minority health-related resources.

CONTACT US ...

If you have story ideas or articles to share, or would like to provide comments, please e-mail Gail Burns-Grant at gab2@cdc.gov or call (404) 639-8126.

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