

Consultation to Address STD Disparities in African American Communities

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Meeting Report



Division of STD Prevention (DSTDP)
National Center for HIV/AIDS, Hepatitis, STD and TB Prevention (NCHHSTP)
Centers for Disease Control and Prevention (CDC)
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DEPARTMENT OF HEALTH AND HUMAN SERVICES



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Key Themes

Overview

Understanding the myriad dynamics that converge to cause disproportionately high STD rates among African Americans in the U.S. today is a daunting undertaking. The problem's scope is most fully grasped from multiple perspectives—epidemiological, sociological, and even spiritual. All point in the same direction: STD disparities reflect socioeconomic disparities, which in turn reflect deep-rooted racial inequalities that continue to exist and are metastasized throughout American society.

Daunting forces are arrayed against those attempting to eliminate racial STD disparities. Doing so completely and sustainably requires rooting out racial inequality. Yet, constructive change is achievable, as evidenced by the inroads forged by successful reductions in disparities in other diseases.

Required are: innovative approaches that expand the health paradigm, standardization of disparity measurement, engagement of national and local leaders, mobilization of communities, advocacy on communities' behalf, community-appropriate issue framing, reforms in health care delivery, partnerships with activists who share the same goals, and integration with the campaigns against other disease disparities and that share the same root causes.

Context

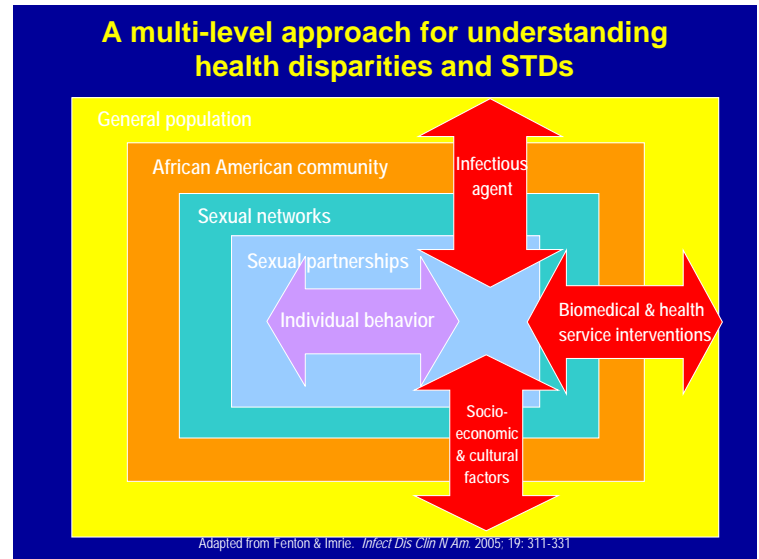
Experts in a variety of fields with diverse perspectives on public health, infectious diseases, and health in African-American communities gathered with CDC policymakers within the Division of STD Prevention (DSTDP) and the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) for this seminal conference focused on combating the bacterial STDs disproportionately burdening African American communities.

The presenting experts came from a wide cross-section of fields, representing academia, federal and local government, faith-based organizations, grassroots organizations, the private-sector, and the community. Insights shared concerned both the causes of racial disparities in STD rates and how best to combat them.

Key Learnings

America's racial disparities in STD prevalence have multiple causes that interrelate in complex ways.

Dr. John Douglas, Director of CDC's Division of STD Prevention, offered a pictorial framework for understanding the contributors that converge to drive up STD rates among African Americans disproportionately. As shown in the graphic, sociological and cultural factors join with epidemiological, behavioral, health care system, and policy-related factors.



The causal complexities compel multiple perspectives for 360-degree comprehension of the problem's scope.

Such multi-level causal dynamics compel multi-level conceptual perspectives, which the various experts presenting at the conference provided:

- ▶ *Epidemiological.* There are significant disparities in bacterial STDs that affect African American communities throughout the nation.
- ▶ *Sociological.* Sociological determinants such as sex partner concurrency, dissortative mixing, and segregation influence STD rates in African-American communities. Contextual factors such as racial and economic oppression, high rates of incarceration, and drug abuse play an important role in sexual partnering decisions.
- ▶ *Behavioral.* Individual-level behavior puts one at risk of acquiring an STD—but to a different extent depending on race. Unlike whites, African Americans need not engage in high-risk behavior to be at high risk of contracting an STD owing to the greater prevalence of STDs in African-American communities.
- ▶ *Structural.* Health care-related and health care policy-related structural factors contribute to the high STD prevalence. Health care access and quality varies dramatically among populations and is worse in higher-STD-risk areas. Moreover, timeliness of detection and treatment affects prevalence in a community, so improving access to acceptable health care should be part of the solution.
- ▶ *Statistical.* Measurement of disparities is an area that can either add clarity or further confuse issues. Standardized measurements and definitions of such terms as “parity” and “disparity” must be created in order to assess progress toward—and accomplishment of—end-goals.

- ▶ *Epistemological.* There are alternate “ways of knowing” less familiar to Western-educated thinkers that must be embraced for full perception of the “human condition in its most troubled state”—of which STD disparities are just one symptom. Appropriate responses to the problem depend upon this deep understanding of the experiential reality of the people involved.
- ▶ *Spiritual.* The faith factor—belief in a redemptive dynamic—must be operative in the work for it to succeed.

Importantly, all of these perspectives dovetail and point to the same broad conclusion about the root cause of racial health disparities: deep racial inequality in America.

■ **Daunting forces are aligned against the task of eliminating racial STD disparities, but the goal is achievable with the right approaches.**

If racial inequality is the key underlying cause of the glaring disparities in health outcomes between peoples in the same nation, then it stands to reason that to achieve a complete and lasting solution to the problem, no less than uprooting the inequality that is deeply entrenched in America’s institutions—its educational, criminal justice and correctional, and public health systems—is required. Various opinions regarding the CDC’s role in such an undertaking were aired at multiple points throughout the conference.

Notwithstanding the daunting odds of total success, significant progress toward eliminating racial health disparities has been made for other diseases, and the stories of strategies employed in those campaigns offer both reasons for optimism and practical advice:

- ▶ *Syphilis.* An impressive turnaround in STD rates was achieved in Marion County, Indiana, when its number-one syphilis ranking in the nation rallied the community—leaders and members—against the disease, highlighting the power of community engagement.
- ▶ *HIV/AIDS.* CDC’s initiatives combating racial disparities in HIV/AIDS are making progress via community mobilization, wide-reaching screening, and researchers who are demographically similar to target populations.
- ▶ *Tuberculosis.* TB initiatives by a coalition of health organizations and like-minded participants on a variety of fronts—e.g., education/awareness, networking, political will—are underway, though it’s too soon to see an impact on disparities.

■ **What’s required now: a multi-pronged strategy that engages multiple stakeholders in the cause of decreasing STD disparities.**

Operationalizing what needs to be done is a complex multi-level, endeavor. But the conference yielded no shortage of suggestions by presenters and external consultants. Some of the many requirements mentioned for successful interventions:

- ▶ Standardization of progress measurements and terms such as “parity” and “disparity.”
- ▶ Engagement up and down the spectrum of stakeholders (from national and local leaders to the affected communities).
- ▶ Mobilization of affected communities.
- ▶ Community advocacy by those attempting to effect change.
- ▶ Community-appropriate issue framing and message delivery that is targeted to and resonates with specific segments of at-risk communities.
- ▶ Innovative and holistic approaches that expand the health care paradigm.
- ▶ Reforms in health care delivery, including expanded screening and improvements in health care access and quality.
- ▶ Reforms in health care policy.
- ▶ Partnerships with activists who share the same broad societal goals (such as eradicating poverty, improving health, reproductive rights, etc.).
- ▶ Integration with both the campaigns against disparities in other diseases and with social movements to empower the disadvantaged and eradicate disparities in socioeconomic opportunity.

A common theme that ran throughout the two days: American society in general must pull together, engaging everyone from the power brokers to the disenfranchised, to collaborate and confront head-on the difficult issues of race and sex that perpetuate STD disparities. Racial disparities in health outcomes are symptomatic of a broader society that is not well. Rectifying STD disparities will mean a healthier America with countless benefits for all of its citizens.

Meeting Objectives

- Moderator: **Deidra Parrish, MD, MPH & TM**, Post-meeting Liaison, Division of STD Prevention (DSTDP), Centers for Disease Control and Prevention (CDC)
- Speakers: **John Douglas, MD**, Director, DSTDP, CDC
Kevin Fenton, MD, PhD, FFPH, Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), CDC

Overview

Reducing disease disparities among racial groups is a priority of the Centers for Disease Control and Prevention (CDC)—and an achievable one. CDC has succeeded in narrowing syphilis disparities among African-American communities dramatically with a national campaign launched in 1999. Within the past year, CDC has embarked on campaigns to fight the disproportionately high rates of HIV/AIDS and TB infection among African Americans. Now it is time to target bacterial STDs such as chlamydia and gonorrhea—both staggeringly and disproportionately high in African Americans.

Context

Drs. Fenton and Douglas welcomed the consultants to this historic meeting and briefed them with some background information on what led up to it and what is expected to come out of it.

Key Learnings

■ **Reducing high racial disease disparities rates is doable—as CDC’s progress on syphilis attests.**

Since its creation in 1995, eradicating racial and ethnic disease disparities has been a top priority for NCHHSTP, dedicated to the “elimination, prevention, and control of disease, disability, and death caused by HIV/AIDS, non-HIV retroviruses, viral hepatitis, other STDs, TB, and non-TB mycobacteria.” The Center’s additional priorities are: 1) program collaboration and service integration and 2) maximizing global synergies.

The Center’s STD elimination efforts have yielded successes over the past decade, most notably in syphilis. A national campaign against syphilis launched in 1999 (and updated in 2006) focused on African-American women—who are pivotal to reducing syphilis rates in children. That campaign succeeded in slashing congenital syphilis rates by 44% and cutting disparities for primary and secondary syphilis between African Americans and whites dramatically, to 5:1 currently from 44:1, which was the highest of all infectious disease disparities in the early 1990s.

The syphilis successes notwithstanding, there are still challenges to syphilis elimination: syphilis rates have begun to increase, especially among men who have sex with men (MSM). Victory over syphilis can’t be declared yet—the rates are still too high.

“This was not a sprint for syphilis, and remediating disparities won’t be a sprint for any other disease.”
— Dr. John Douglas

■ **This meeting will shape CDC’s attack on chlamydia and gonorrhea.**

Over the past 18 months, CDC has looked critically and systematically at racial disparities for all diseases—exploring the driving factors behind them and what is needed to reduce them. This effort resulted in a heightened national response to HIV among African Americans launched in March 2007 and a program targeting TB rates in African Americans begun in summer 2006.

Now, the focus is on STDs. African American-to-white disparities for chlamydia (8:1) and gonorrhea (18:1, the highest for any disease) remain, in Dr. Douglas’ words, “glaringly and embarrassingly dramatic.”

This important consultation sets the wheels of strategy formation in motion as the CDC begins to tackle the unacceptably high disparities in bacterial STDs that plague African-American communities. The initiative that results will be integrated with the HIV and TB programs already underway.

“Today’s meeting is historic, but—as many of you have pointed out—not before its time.”

— Dr. Kevin Fenton

■ **This consultation was convened to illuminate the drivers of STD disparities, to inform and guide CDC strategy.**

This consultation gathers together experts from outside CDC with a variety of perspectives on public health, infectious diseases, and health in African-American communities. The objective is to share information on the contributing factors and ramifications of bacterial STD disparities and then to formulate strategy and next steps in CDC’s disparity-elimination efforts. Specifically, the meeting’s activities include:

- ▶ Reviewing the epidemiology of bacterial STDs, with a focus on gonorrhea, in African-American communities.
- ▶ Discussing the determinants that contribute to disparities in bacterial STDs among African-American communities.
- ▶ Discussing the individual, social, and health impacts of the disparities of bacterial STDs in African-American communities.
- ▶ Developing next steps for CDC and meeting participants to address STD disparities among African-American communities, entailing: 1) outlining specific strategies for addressing disparities in bacterial STDs, especially gonorrhea; 2) identifying how specific strategies should be communicated and framed for African-American communities; and 3) identifying opportunities for collaboration with other campaigns addressing other sexual health issues such as HIV, herpes, and hepatitis B.

■ **Ongoing workgroups will help CDC formulate and operationalize a disparity-eradication strategy.**

Short term, the anticipated output from this meeting is threefold:

1. Establishment of workgroups consisting of CDC and external partners, which will continue collaborative post-meeting activities for at least the next year.
2. Development of specific goals and actions, which participants are committed to trying to achieve in the next year.
3. Production and dissemination of this summary report documenting meeting content and output.

The long-term objectives of this initiative are:

1. Development of a strategy by CDC's Division of STD Prevention (DSTDP) for addressing STD disparities among African Americans.
2. Establishment of an STD disparities steering committee or workgroup to advise CDC DSTDP.
3. Monitoring and evaluation of post-meeting activities.

Epidemiology of STDs in African American Communities

Speaker: **Lori Newman, MD**, Meeting Co-Chair, DSTDP, CDC

Overview

Gonorrhea is the disease with the largest disparity between African Americans and whites. It is 18 times more prevalent among African Americans than whites and represents a public health concern in 95.6% of U.S. counties where blacks make up 15% or more of the population. Chlamydia and syphilis show lower but still striking disparities. STD disparities can't be explained by risky behaviors or sociodemographic factors alone. Sexual network dynamics play a significant role that interventions must address.

Context

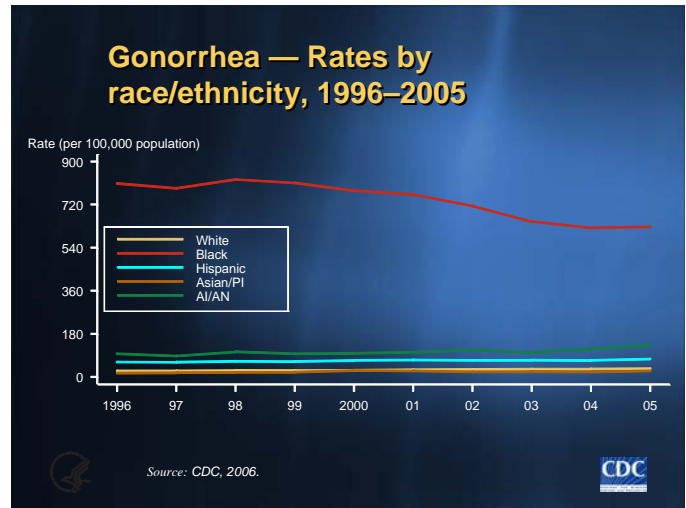
Dr. Newman discussed the epidemiology of STDs in America today focusing on the disparities in African-American compared with white communities, by disease. This epidemiological discussion laid the groundwork for the meeting, highlighting the need for it and allowing participants to start with a common understanding of the problems.

Key Learnings

- **STD disparities are greatest for gonorrhea and congenital syphilis but also high for chlamydia and adult syphilis.**

Of all notifiable diseases, the largest disparity exists in the rate of gonorrhea among African Americans and among whites. Two other STDs—chlamydia and syphilis—also show significant disparities. Consider these statistics:

- ▶ **Gonorrhea:** Of all the cases of gonorrhea reported to the CDC in 2005, 68% occurred in African Americans. The "rate ratio"—i.e., the ratio of the rate per 100,000 population among African Americans divided by the rate among whites—that year was 18. Among African American adolescent females (aged 15-19), gonorrhea rates are higher than for any other race/age/gender group; approximately 3% of African-American adolescent females had a reported case of gonorrhea in 2005 (specifically, 2,814 per 100,000 population). But *disparities* in gonorrhea rates between blacks and whites are greatest for adolescent males, with a rate ratio of 35.7 in 2005. Accordingly, these two groups, African-American adolescents of both genders, represent important target populations for interventions.



- ▶ **Chlamydia:** An estimated 41.6% of all chlamydial infection cases reported in 2005 occurred among African Americans. The rate ratio shows the disease striking African Americans eight times more often than whites. Chlamydia infection is commonly asymptomatic in both men and women; however, screening practices play a large role in identifying cases, and screening practices may vary between races. Accordingly, case report data for this disease is believed to have important limitations.
- ▶ **Congenital syphilis:** Racial disparities for congenital syphilis (based on rates among infants less than one year of age, by the mother's race/ethnicity) are as striking as for gonorrhea, with a rate ratio of 19.9 in 2005.
- ▶ **Primary and secondary syphilis:** Of the primary and secondary (i.e., recently acquired) syphilis cases reported in 2005, roughly 41% occurred among African Americans. The disparity rate ratio, however, is the lowest of the bacterial STDs, at 5.4 in 2005.

Interestingly, viral STDs show lower disparities between African Americans and whites. HIV rate ratios are approximately 8. But herpes and hepatitis B have ratios of 3, HPV 1 (parity) and reported history of genital warts less than 1 (meaning it's more prevalent among whites than blacks).

- **For nearly all African-American communities, gonorrhea is a major public health concern; among white communities that is rarely the case.**

Case report data for gonorrhea and chlamydial infection clearly show a disproportionately large number of cases in the South. This is to be expected knowing that African-American communities are hardest hit, since the South has the most counties where African Americans represent 15% or more of the population.

A county-level map of gonorrhea rates demonstrates that in 95.6% of African American communities, the rates exceed 100 per 100,000 population; that's true for only 0.5% of white communities. Thus, gonorrhea is a significant public health issue for nearly all African-American communities, but it's a problem for hardly any white communities. This suggests that African-American communities must take up the STD elimination charge, as other communities may not prioritize STDs as a public health issue of importance.

"There are no African American communities that are spared. Yet [because prevalence is so low among white communities] it's going to be hard to mobilize white communities to view this as a public health priority."

— Dr. Lori Newman

Looking at disparities by region demonstrates greater rate ratios in the Midwest (25.7) and Northeast (22.8) than the South (14.7) and West (11.8).

■ **Attempts to improve bacterial STD control need to go beyond changing individual risk behavior.**

Both individual risk behavior and sociodemographic factors may play some role in disparities, but these two factors cannot fully account for the disparities between populations. Studies controlling for risk behaviors and sociodemographic factors still show high STD rate ratios. Consider:

- ▶ **Individual risk behaviors:** Modern epidemiology has tended to focus on individual risk behaviors, but STD disparities cannot be fully explained by differing risk behaviors among ethnic and racial groups. Studies have shown that when individual risk behaviors (e.g., number of partners, condom use, drug use) are similar in white and African-American populations, STD rates remain higher among the latter. One study published this year grouped 18- to 26-year-old participants into risk groups by sexual behavior and drug use. Over one-third of African Americans (37.6%) and only 12.7% of whites fell into the lowest risk group. Yet the low-risk African Americans nevertheless were 7.8 times more likely to become infected with HIV than their white counterparts.
- ▶ **Sociodemographics:** Linkages between sociodemographics and STD rates have been demonstrated. A study of African-American female adolescents found that those with unemployed parents were twice as likely to report a history of gonorrhea as those with employed parents. But several studies also show that controlling for sociodemographics still fails to fully account for African-American adolescents' much higher risk of contracting STDs.
- ▶ **Sexual networks:** Differences in sexual network characteristics may be a key causal link. Researchers have found that STDs may be more widespread among African Americans because partner choice in these communities is more "dissortative"—meaning that low risk African Americans (i.e., who have had only one partner during the past year) are five times more

likely to choose higher risk African Americans (four or more partners) than is the case for their white counterparts. Possible reasons include the gender imbalance in many African-American communities (owing to the higher incarceration and mortality rates of black men) that drives peripheral women to partner with core men. The study also suggested that STDs tend to remain in the African-American population because partner choices are more segregated than among other groups. Another study showed that low-income black adolescents who were "highly connected" (i.e., whose sex partners reported having another sex partner) were more likely to have had a recent partner with an STD.

A key learning from these studies is that bacterial STD control programs must go beyond attempts to modify individual risk behavior and focus instead on interventions that affect broader sexual networks.

■ **Strategies should focus on broader sexual networks and be integrated into a comprehensive approach.**

Traditionally, STD prevention and control strategies have included surveillance, clinical services, partner management, and behavioral interventions. These strategies are often viewed and implemented independently of each other. For best results, however, they should function in seamless coordination to form an overall comprehensive approach.

Moreover, these traditional strategies should be tailored to meet the needs of African-American communities in order to enhance outcomes and improve these communities' overall health. To accomplish this, strategy creators must deepen their understanding of the interrelated causal dynamics driving disparities—such as the role of sexual networks—so as to understand when to apply the existing strategies and when new approaches might be in order.

For example, strategies to influence behavior in sexual networks might include identifying "core" populations, focusing on the importance of partner management, and adjusting screening criteria to best provide services to those in greatest need.

"Epidemiology can really assist in targeting our intervention activities."

— Dr. Lori Newman

Other Important Point

- **Black-and-white comparison.** The reason white communities are used here as a reference point when measuring disparities—even though whites are not always the group with the most favorable rates (for gonorrhea, for example, Asian/Pacific Islanders have that distinction)—is that they represent the largest and the most socioeconomically advantaged group in the U.S., allowing disparities to be framed in a social justice context.

Framework for Understanding Disparities

Moderator: **Beny J. Primm, MD**, Executive Director, Addiction Research and Treatment Corporation

Speaker: **Sevgi O. Aral, MS, MA, PhD**, Associate Director of Science, DSTDP, CDC

Overview

The causes of racial/ethnic health disparities are complex. Socio-economic cofactors are so entangled with issues of race—and in the case of STDs, sexual behavior—that the causal relationships are often hard to discern. But research has shown that socioeconomic status, poverty, and geography are significant determinants of STD disparities—while risky sexual behavior decidedly is not. A conceptual framework clarifying the interplay of the various disparity determinants pinpoints where interventions might best succeed.

Context

Dr. Aral presented a conceptual framework for understanding the reasons behind racial/ethnic disparities in bacterial STD rates, as a foundation for understanding where to focus intervention efforts.

Key Learnings

■ **The causes of racial/ethnic health disparities are complex.**

Racial/ethnic health disparities are not unique to STDs; they are observed in many chronic and infectious diseases—cancer, diabetes, cardiovascular conditions, TB and lead poisoning—conditions that have nothing to do with sexual behavior.

The reasons for disparities are complicated—race and ethnicity do not account for differentials in health outcomes in general or STDs in particular. Poverty, income, and socio-economic status are important co-determinants. However, these cofactors are so entangled with issues of race—and in the case of STDs, with issues of sexual behavior—that the causal relationships are often hard to discern.

In the U.S., socioeconomic inequalities in health and their contribution to racial/ethnic health disparities are poorly documented. Because U.S. public health surveillance systems do not routinely collect socioeconomic status data (the exception is education level in birth and death certificates), our understanding of how economic and non-economic aspects of racial discrimination contribute to U.S. racial/ethnic health disparities is deeply limited.

■ **Studies show socioeconomic status, poverty and geography to be major determinants of STD disparities.**

Although the causal relationships are complicated, some studies have shed light on linkages between socioeconomic status and health disparities:

- ▶ *Income and poverty play a big role in health disparities.* The Public Health Disparities Geocoding Project by Nancy Krieger et al. in 2005 found that for a variety of health disparities (lead poisoning, TB, nonfatal weapons-related injuries, and more, including STDs) risk increased with poverty; and when poverty was adjusted for, the disparities were substantially reduced. In over half of the health outcomes examined, more than 50% of cases would have been eliminated had incidence rates equaled those of the least impoverished groups.
- ▶ *Geography is an important correlate of racial health disparities as well, with implications for health care access interventions.* A 2003 study by Amitabh Chandra and Jonathan Skinner learned that: 1) both hospitals and provider groups in the U.S. treat African-American patients differently than whites; and 2) African Americans live in areas or seek care in regions where health care quality for all patients is lower. The differential treatment and poor care that blacks encounter when they enter the health care system mean that even providing equal access to care at the local level may not erase overall disparities. But reducing geographic disparities in quality of care should help improve racial disparities in health care and health outcomes.
- ▶ *The “Eight Americas” model of mortality disparities may have applicability for STD disparities.* In the fall of 2006, researchers at the Harvard School of Public Health unveiled their “Eight Americas” study of mortality by U.S. county and race. Race/county combinations were grouped into eight Americas (three of them black), with large and stable disparities in life expectancies (the widest disparities were unchanged in absolute terms from 1982 to 2001). Attempts to look at gonorrhea and syphilis rates with this model are preliminary but suggest that the three black Americas have much higher rates than any of the others Americas. Disparities in gonorrhea and syphilis apparently mirror other health disparities among race-county units in the U.S.
- ▶ *Infectious diseases’ determinants include prevalence in the community.* For chronic conditions such as cardiovascular disease, health disparities are functions of health status, health care access, quality of care received, and health care outcomes, according to research by LaViest et al. and Smedley et al. In infectious diseases like STDs, the determinants are more complex. The timeliness of detection and treatment affects prevalence in the population, and is indeed an important determinant of prevalence. So community access to acceptable health care that promotes good outcomes is a bigger issue in combating STDs than with chronic conditions.

■ **Risky sexual behavior, however, is not a significant factor accounting for disparities.**

Back in 1978, most people thought there was a 1:1 correlation between individuals' sexual behavior and their risk of contracting a STD. Today, data show that this is not the case.

Sexual risk behavior—measured in terms of number of partners, sexual practices, condom use, and other individual-level parameters—does not account for the observed racial disparities in STDs. African-American women have the highest STD rates in most analyses, but studies show they do not have the highest levels of risk behavior. One study found that:

- ▶ Unmarried black women of all ages studied (six groups ranging from 15 to 44 years of age) were less likely to have had four or more partners in the past year than their white counterparts. And a lower percentage of black women reported having had 15 or more partners in their lives than white women. Lower percentages of African Americans in general (men and women) had ever engaged in oral or anal sex than whites. In fact, among women, whites topped both blacks and Hispanics in these risk-associated behaviors.
- ▶ Looking at the prevalence of pelvic inflammatory disease for white and black women by the number of lifetime partners, the odds ratio clearly rises for both groups with a greater numbers of partners, but it rises to a greater extent for blacks with each successive partner.

For each unit increase in sexual risk compared to white women, an African-American woman's risk of an adverse health outcome increases manifold.

"Having a sexually transmitted infection does not mean a person engaged in risky behaviors."

— Dr. Sevgi O. Aral

Other studies (Denise Halfors, et al.) show that African-American communities' sexual partnering patterns are more segregated than other ethnic groups' and that these communities show high levels of "mixing" between high- and low-risk groups (typically it is low-risk women with high-risk male partners).

"The sexual segregation of African American communities, plus much mixing between high- and low-risk groups, creates a 'perfect storm.'"

— Dr. Sevgi O. Aral

■ **A conceptual framework for viewing STD disparity determinants highlights where to focus interventions.**

Taking the above data in aggregate, a clearer picture of STD determinants and how they interrelate at both the individual and the population levels emerges. At the individual level:

- ▶ The most important risk factor for acquiring an STD is having sex with an infected person.

- ▶ The most important determinant of having sex with an infected person is the prevalence of infection in one's sex partner pool.
- ▶ The most important determinant of the prevalence of infection in one's sex partner pool is the prevalence in the population from which one chooses partners.

At the population level:

- ▶ The size of the high-risk group as well as the mixing between high-risk and low-risk ("core" and "periphery") groups determine population prevalence.
- ▶ Because sexual mixing between African Americans and whites is limited, whites and blacks constitute separate populations with regard to STD epidemiology.
- ▶ The reason for such dramatic race differentials relate to the social determinants (including sex ratios in communities, incarceration, unemployment, health care access and quality, migration, segregation and poverty) and how they impact upon more direct causal factors such as sexual mixing patterns, concurrency of partners, number of partners and duration of infection.

"A white person needs to engage in high-risk behavior to acquire an STD; for a black person low-risk behavior is sufficient because prevalence is so high."

— Dr. Sevgi O. Aral

From this clearer picture of the interplay of determinants emerges a conceptual framework for understanding the causes of STD disparities between African Americans and whites in America today:

- ▶ Sexual mixing patterns and health care issues (accessibility, acceptability, and quality) together determine population prevalence and incidence.
- ▶ Population prevalence determines an individual's risk of contracting an STD.
- ▶ That risk, combined with the health care issues, bears on an individual's risk for developing sequelae (such as pelvic inflammatory disease or infertility).

Viewed with this conceptual framework, at least two intervention points become apparent. These are: health care and sexual mixing. Strategies to lower STD disparities could focus on black communities' sexual partnering patterns and on improving the quality, access, and acceptability of health care in geographic areas where African American populations are concentrated.

Social Determinants of STDs

Speaker: **Adaora Adimora, MD**, University of North Carolina

Overview

Societal factors contribute to the risk of acquiring an STD. Poverty, inequality, and discrimination are distal determinants that shape both behavior and risk of infection associated with behavior. They have bearing upon the proximate causes of STDs—such as prevalence in the community and disease-perpetuating sexual network patterns.

Because contextual societal factors raise the odds that a given behavior will result in infection, it is important to expand the public health paradigm to address these factors. Policymakers should develop structural interventions that alter the context of life for STD-burdened communities.

Context

Drawing heavily on studies of HIV risk factors, Dr. Adimora explained the epidemiological determinants of STDs on both individual and societal levels—and the implications for structural interventions to reduce STD rates.

Key Learnings

■ HIV/AIDS research reveals risk cannot be fully explained by individual behavior; societal context plays a role.

Much research has gone into understanding HIV risk-factor epidemiology on both the individual and societal levels:

- ▶ *Individual: What places people at risk of getting HIV?* A broad conclusion of the aggregated research: risk of HIV/AIDS is manifest at the individual level. The implication of this for interventions: they should focus on individual behavior change to prevent HIV transmission.
- ▶ *Societal: What places populations at risk of HIV epidemics?* A broad conclusion: social determinants affect HIV risk by shaping patterns of population susceptibility and vulnerability. Policy and program interventions that address social determinants enable large decreases in HIV at the population level.

But societal determinants not only escalate a community's risk—they escalate risk on the individual level as well.

The Rural Health Project was a study of African Americans in North Carolina with heterosexually acquired HIV. Most HIV-positive participants reported high-risk behavior and/or high-risk partners, for which odds ratios of contracting the virus rise. But importantly, 27% *did not* (versus 69% of the control group). This significant portion of individuals *denied* all of the risk-associated behaviors (crack smoking, binge alcohol abuse,

STDs over the past year and trading sex).

A multivariate analysis, however, demonstrated that these lower-risk study participants had risk factors that increased their odds of contracting the virus. These factors had relatively little to do with high-risk behavior. They included: having less than a high school education, having experienced food insecurity (i.e., uncertainty about having sufficient food—a reflection of poverty), having an annual income of less than \$16,000, and having a non-monogamous sex partner.

■ Sexual network patterns were important societal context risk factors.

Dr. Adimora's research has found that sexual network patterns are key to the sexual transmission of HIV and STDs—three in particular:

- ▶ *Concurrency.* This refers to sexual partnerships that overlap in time. The practice permits more rapid spread of an STD throughout a population because an individual infected by one partner infects others right away. Concurrency prevalence among black women in the study was higher than in other ethnic groups, largely because of lower marriage rates among African Americans, due in large part to the shortage of black men.
- ▶ *Dissortative mixing.* "Dissortative mixing" (a.k.a. "mixing" and "bridging") refers to the partnering of low-risk members of a community with high-risk members. The practice facilitates dissemination of an STD throughout a population. The opposite is assortative mixing, or partnerships between people at similar risk for infection. Assortative mixing keeps infection within the same-risk population. Most social and sexual networks are assortative, but many African Americans' sexual networks are dissortative—and indeed, the low-risk females in the Rural Health Project had dissortative mixing patterns, partnering with high-risk men.
- ▶ *Segregation.* Residential segregation by race concentrates adverse social and economic influences (poverty, drugs, and violence), which increases residents' (especially youth's) likelihood of risk behavior. And selection of sexual partners from within one's neighborhood raises the odds of encountering an infected partner even without participation in risk behavior. Segregated partner choice keeps infections within the community.

The high levels of concurrency, dissortative mixing, and segregated partner choice in African-American communities contribute significantly to the disproportionately high prevalence of STDs in that population.

■ Contextual factors of life bear heavily on sexual

partnering decisions.

Why are African-American populations different from others in terms of sexual mixing patterns? These proximal causes of STDs reflect deeper distal causes—related to the different worlds experienced by many blacks and whites in America today.

Focus group studies conducted by a minority-owned research company examined the life circumstances of black men and women in eastern North Carolina. In describing the contexts in which they live, focus group respondents cited:

- ▶ Pervasive economic and racial oppression;
- ▶ Lack of community recreation, boredom, and resultant substance abuse;
- ▶ Shortages of black men (high rates of mortality and incarceration remove many from the community);
- ▶ Widespread concurrency among unmarried people.

Most participants said that community race relations were poor and described residential segregation. But their concerns focused on *institutional racism*, such as the preferential hiring and job advancement of whites, blacks' inability to get mortgages, and academic tracking of black youth in schools.

"It's hard to get a loan to get a house. Banks don't just give black people loans. You got to know somebody."
— Focus Group Participant

These contextual factors in the lives of focus group participants—the racial and economic oppression, the disparity in sex ratios owing to black males' high rates of incarceration, drug abuse, and mortality, etc.—had clear bearing upon sexual network patterns. In response to fewer available men, in particular, mixing is dissortative and concurrency is common:

- ▶ *These communities' gender relationship realities promote dissortative mixing.* Respondents perceived a huge disparity in the ratio of available black men to women because of male attrition due to incarceration, drug addiction, and death. Some women noted gender inequality and women's perception that they are dependent on men, especially women who are poor or had low educational attainment.

"The choices in men are very limited around here. I guess the women put up with the men they have because there aren't that many."
— Focus Group Participant

- ▶ *Concurrent sexual partnerships are more common in these life circumstances.* Concurrency was described as widespread among unmarried men, a function of the skewed sex ratios. Moreover, having a partner incarcerated is a concurrency correlate—increasing the frequency of this practice among women. So the male shortage and the

socioeconomic plight of both black women and men profoundly affect their partner selection—and the types of male behavior (such as "cheating") that women tolerate.

"There are so many black men in prison, strung out on drugs, or dead, that if a decent black lady finds a decent black man, she's going to do whatever it takes to get him."
— Focus Group Participant

- **Since STDs have major contextual determinants, the public health paradigm must expand to encompass interventions that alter the context of life.**

The implications of this research are sobering and point to a daunting task for policymakers and others determined to eliminate racial disparities in STDs.

"Because contextual factors are important . . . we must expand the public health paradigm [in ways that] alter the context of life."
— Dr. Adaora Adimora

Since contextual factors play an important role in promoting risk behaviors and in increasing the odds that a given behavior will result in an STD, policymakers must expand the public health paradigm. Policymakers must develop structural interventions—programs, laws, and policies—that alter the context of life for STD-burdened communities in ways that will improve health behaviors and health outcomes.

Other Important Point

- **Incarceration ramifications.** High incarceration rates among black males affect communities in several negative ways: 1) partnerships are physically disrupted; 2) in-prison sex partners from high-HIV-prevalence pools are common; 3) partners left behind seek support in concurrent relationships; 4) inmates make long-term links with antisocial networks; 5) once released, high-risk males return to low-risk partners (dissortative mixing) or engage in new concurrent relationships, possibly dissortative; 6) dim employment prospects destabilize long-term relationships; 7) communities suffer from high unemployment, low numbers of men, and low numbers of financially viable men.

Perceptions of Sexuality, Faith and STDs in African American Communities

Speaker: **Edwin Clifton Sanders, II**, Senior Servant and Founder of the Metropolitan Interdenominational Church

Overview

Western-educated thinkers addressing the STD disparities problem must stop looking for *what* to think and change *how* they think. Consciousness must expand beyond the limitations of logic to fully grasp the social context of the people involved. Advocacy is the response to grasping this plight (“perceiving the human condition in its most troubled state”) and instrumental to any sustained success in STD disparities elimination interventions. Community mobilization, community empowerment, and faith in a redemptive dynamic are also instrumental.

Context

Drawing on the experience of his church’s successful approach to STDs in Nashville, Reverend Sanders explained how those spearheading change must change themselves if their efforts are to succeed.

Key Learnings

- **The STD disparities problem will not be solved without expanding thought beyond the limitations of logic.**

Reverend Sanders attributed the successes of the STD program in Nashville to expansive thinking by a coalition of parties united in a common cause. It worked only because of their willingness to understand the people affected; to be creative, open, broad-minded, and unconventional in their approaches; to get out of their “comfort zones.”

As researchers focus on the socioeconomic inequalities that represent the root causes of STD disparities and as others use their findings to devise corrective strategies, all should know that they must move beyond logically-derived conclusions. Instead of seeking to learn *what* to think, they must seek to learn *how* to think.

“A Western world view doesn’t lend itself to discovery of the kinds of responses we need to deal with this problem. We have to revisit how to think.”

— Reverend Edwin Clifton Sanders, II

We all think in ways shaped by our culture, context, and society—the byproduct of our human experience. In the African-American psyche, there’s a “haunting dynamic—foundational scars born of hurtful, dehumanizing realities”—revisited over and over. These scars are central to the ways sexuality in the culture is framed and understood. Accordingly, the STD disparities issue has to be understood in that context.

Those who would tackle the problem must be able to perceive the culture, the people, and their travails—“the human condition in its most troubled state.” Otherwise, intervention efforts will meet with limited success.

The effectiveness of STD interventions depends on how the communicator or intervener sees the audience. This determines how one chooses to frame issues, shape strategies, and develop responses. Accordingly, the outcome of any STD intervention will be less than optimal if information dissemination is not 1) acceptable to the communities served; 2) faithful to deep understanding of the issue; 3) reflective of a refusal to compromise; and 4) inclusive of the people—they have to be a part of the equation.

- **If advocacy on behalf of the communities isn’t central to the solution, the work will be compromised.**

Because the problem of STD prevalence in African-American communities reflects a litany of socioeconomic realities, one can’t talk about STDs in isolation. The problem can’t be isolated from the context that festers it—poverty, truncated educational opportunities and high rates of incarceration. Those problems, once perceived fully, compel advocacy.

“Advocacy responds to the human condition in its most troubled state.”

— Reverend Edwin Clifton Sanders, II

Advocacy must be a part of STD prevention and control, and those doing the work must get in the middle of the problem, engage with the community and cultivate advocacy relationships.

They should approach the work knowing that they must challenge traditional assumptions and structures that perpetuate the status quo. For instance, they should confront institutions with responsibility for solving the STD disparity problem that have been inadequate to the task. This inadequacy means there must be something about these institutions’ structure, design, or processes—“something about the way they simply exist”—that warrants questioning at least.

People within the CDC must do that critique of the CDC regularly. The syphilis issue appeared to be resolved, then rates started to climb again. There is something health policy-makers still aren’t getting.

- **If communities are not united with a discipline of compassion, the work will be compromised.**

One cannot succeed at advocacy objectives by being outside of the communities. And the affected communities cannot remain excluded from the process. Mobilization of

communities is instrumental, and communities must be held accountable for their actions.

"We have to be about mobilization."
— Reverend Edwin Clifton Sanders, II

Looking at the problem from the perspective of within the community, one sees a behavioral imperative. A dysfunctional belief system within many STD-burdened communities perpetuates their self-destruction and contributes to the status quo. A discipline must be imposed upon the community, driven by caring and compassion for one another. Instead of sending messages that play to a person's fear of contracting an STD (messages that won't work anyway), messages should focus on not giving an STD to someone else; on regular screening and informing partners at risk. Faith leaders can be important in uniting the community with the discipline of selflessness, personal responsibility, and compassion.

Additionally, the community mobilization and unification must occur in a way that exclusivity is not a by-product, as it has been with so many human endeavors throughout history. We are all inseparably connected, and the benefits of repairing the social ills disenfranchising many African Americans will have beneficial ripple effects throughout American society. The core values of any solution must be redemptive, liberating, and inclusive.

■ **If the disenfranchised are not empowered, the work will be compromised.**

The faith factor comes into play in both motivating the community to join together and keeping those effecting change from looking at the daunting facts aligned against success and "throwing in the towel." Success can be a powerful motivator—"Look what you get when the work is done well." Solving the problem of STDs and HIV disparities solves all the other problems that are "haunting and destroying and undermining our communities."

If done well, this work will "empower the disinherited." It will empower the community in a way that allows it to take ownership of the problem. Members then will do what it takes to move beyond the barriers that have constrained attempts at reform in the past.

"This issue is bigger than STDs. Deal with this, and you're going to deal with the issue of socioeconomic disparities."
— Reverend Edwin Clifton Sanders, II

If the community is not empowered, then no matter how good the statistics measuring an intervention's success look, the favorable outcome will not be sustained. That is because the intervention will not have dealt with the root causes of the disparities in the first place.

■ **If belief in a redemptive dynamic is not operative within the work, the work will be compromised.**

Finally, those effecting change must believe, despite the daunting facts of the issue, that change is possible. They have to believe the bad situation can be reversed, that life for African Americans can be other than what it is. They have to believe that people can disengage from the organizational structures, the attitudes, and the dysfunctional belief systems that have sustained the status quo and tied the hands of those who desired to change it.

They have to believe in a redemptive dynamic representing a "truth bigger than the facts." They have to believe that people are the handiwork of some "force out there" that operates in the interest of human life. With this redemptive dynamic operative in the work, "the shackles can fall away and the foundational scars will heal."

"If you don't have that faith as an operable part of your work, its absence will compromise your ability to get where you want to go."
— Reverend Edwin Clifton Sanders, II

Reducing Health Disparities: Influences and Opportunities in Health Care Financing and Delivery

Speaker: **Yasmin Tyler-Hill, MD**, Assistant Clinical Professor of Pediatrics, Morehouse School of Medicine

Overview

Underinsured and uninsured, millions of poor African Americans seek health care from funding-strapped and poorly regulated facilities lacking the latest technology—if they seek it at all. STDs are especially problematic in that they often do not cause obvious symptoms. The reasons that many African Americans have inadequate access to quality health care are manifold—including patients' misinformation and distrust of the health care system, poor service in under-staffed and -equipped facilities, and perceptions of provider insensitivity and bias (often rooted in racial stereotypes). To narrow STD disparities in African-American communities, patient education, investments in technology and staff on the health care system level, and increased cultural sensitivity on the provider level must take place concomitantly.

- ▶ *Representation of racial/ethnic groups among health professionals:* African-American patients may have difficulty establishing a trust-based relationship with a physician outside their racial/ethnic group, and the number of African American physicians is insufficient.
- ▶ *Implicit and explicit bias:* Physicians may make negative value judgments about African-American behavior and health based on stereotypes.
- ▶ *Adherence to known care standards:* African-American patients may be distrustful of treatment protocols and, as a consequence, not be adherent to treatment recommendations.
- ▶ *Health care technology:* Health facilities that serve African-American communities may not have access to the latest technology due to funding shortfalls.

"Of all the forms of inequality, injustice in health is the most shocking and inhumane."

— Dr. Yasmin Tyler-Hill, quoting Dr. Martin Luther King, Jr.

Context

Dr. Tyler-Hill, a practicing pediatrician, discussed the impact of health care financing and delivery in mitigating STD disparities in African-American communities.

Key Learnings

■ **Economic, social, and physical factors converge to cause health disparities in African-American communities.**

Today's disproportionate rates of gonorrhea and chlamydial infections among African Americans compared with whites (18:1 and 8:1, respectively) result from three health-care-related gaps: 1) a gap in access to health care; 2) a gap in quality of care; and 3) a gap in health outcomes. The specific conditions contributing to these gaps include:

- ▶ *Geographic location of clinics:* Proximity of treatment facilities to African-American communities often makes it difficult for patients to travel to appointments in a timely manner.
- ▶ *Insurance status and type:* African-American patients are most often uninsured or underinsured. A dramatic lack of insurance among African-American young adults (aged 19 to 29) in particular impairs their access to healthcare.
- ▶ *Provider payment rates:* African-American patients often are unable to meet co-payment or office visit fees.
- ▶ *Linguistic and cultural competence:* Physicians may be unskilled in or uncomfortable communicating in language and/or jargon that African-American patients can understand.

■ **Required at the patient level: educate, educate, educate.**

At the patient level, issues that contribute to disparities include: 1) patient preferences in the care experience; 2) treatment refusal; 3) care-seeking behaviors and attitudes; and 4) the clinical appropriateness of care. Better patient education could help alleviate many of these problems.

Understanding the dynamics of the patient experience is crucial to disparity-eradicating strategies. Some of the dynamics policy-makers need to better understand include:

- ▶ *Patient/provider relationships:* Research has indicated that patients prefer to be treated by doctors who are of the same ethnic/racial background—"people like me." That's a problem: while African Americans compose 13% of the population, they account for only 3% of the nation's physicians. Strategies addressing the racial imbalance in the ranks of physicians might do much to increase African Americans' trust in the health care system and foster the personal relationships between patient and doctor that are often the lynchpin of successful health outcomes.
- ▶ *Mistrust of the system:* Poor African Americans tend to be suspicious of public health organizations, skeptical of receiving adequate treatment and being afforded confidentiality. Many fear being used as guinea pigs (a legacy of the U.S. government's Tuskegee Syphilis Study that from 1932 to 1972 did just that, withholding information about and treatment of the disease from a group of infected black men).

- ▶ **Misinformation:** Also inhibiting patients from seeking care is misinformation they are exposed to anecdotally and/or from the media, which may cause them to ignore or abandon recommended treatment protocols. A 2006 study by Kaiser Family Foundation found that the media accounted for 53% of black Americans' information about HIV/AIDS. The at-risk public should be educated about the necessity for regular STD screening, crucial to inhibiting the spread of STDs, as well as educated about the medical facts concerning STDs and the benefits to themselves and others of seeking treatment and adhering to treatment plans.

■ **Required at the health care system level: increased resources for modern technology and services.**

The health care system at large is grappling with resource shortages that adversely affect health outcomes for racial/ethnic minorities, including:

- ▶ Lack of interpretation and translation services.
- ▶ Time pressures on physicians.
- ▶ Geographic availability of health care institutions.
- ▶ Policy changes in the financing and delivery of health care services.

These are all problems that can be ameliorated with greater political will to make the necessary investments. Much time and money has already been devoted to discussing these issues, but not enough resources have been expended on solving them.

■ **Required at the provider level: heightened cultural sensitivity and awareness of personal bias.**

Preconceived bias regarding the behavior and health of African-American patients can cause providers to have less regard for minority patients and treat them less well. Noncompliance and adverse health outcomes are frequently the result of this racial disconnect.

Moreover, physicians are often ignorant about the causes of racial disparities in STDs, and can believe the high rates in the African-American population are fully explained by high-risk

behavior. Prejudicial and judgmental attitudes, such as African-American young adults are promiscuous, can have an alienating effect on the doctor-patient relationship.

Providers must be aware of the ways in which their personal judgments and biases impact upon the efficacy of care delivery. They should make an effort to gain the trust and respect of their patients and to frankly discuss matters of sexual health with their patients, particularly those at high risk of STD infection.

"Providers must get out of their comfort zone."

— Dr. Yasmin Tyler-Hill

Other Important Point

- **Specialized intervention.** Culture- and gender-specific behavioral intervention programs have been effective in reducing gonorrhea and/or chlamydia transmission rates among Mexican- and African-American women.

Suggested Actions

Health professionals and providers can:

- ▶ Educate the various constituencies about the STD problem within African-American communities.
- ▶ Develop a national discourse and plan of action on STD health disparities in an effort to eliminate them.
- ▶ Support innovative research to identify additional underlying determinants in STD transmission.
- ▶ Develop screening and treatment guidelines to ensure that cases of STDs are diagnosed and treated appropriately.
- ▶ Identify quality indicators that correlate with improved outcomes.
- ▶ Approach STDs with an attitude of primary prevention, as is done with other diseases.

Measuring Health Disparities

Speaker: **Kenneth G. Keppel, PhD**, Statistician, National Center for Health Statistics (NCHS), CDC

Overview

Defining “disparity” and standardizing its measurement are critical for assessing whether elimination efforts are succeeding. Absolute and relative differences between groups can suggest different interpretations, so the best evidence of progress toward elimination of a health disparity is a decline in relative differences of adverse events. Although progress can be monitored and assessed, ultimate success will not be achieved until what it means to eliminate disparities is defined and criteria for distinguishing “parity” from “disparity” are identified.

Context

Dr. Kenneth Keppel discussed methods of measuring health disparities.

Key Learnings

■ **Relative differences of adverse events compared to the best group rate is the best way to measure disparity.**

Because of a lack of a consistent definition for measuring health disparities, a working group was formed to arrive at a definition. The definition: “Disparity is the quantity that separates a group from a reference point for an indicator of health that is measured in terms of a rate, proportion, mean, or some other quantitative measure.” Health disparities are most effectively measured:

- ▶ From the most favorable, or “best” group rate.
- ▶ In terms of adverse (not positive) events.
- ▶ In relative, not absolute, terms. An absolute comparison gives the magnitude of the difference, while a relative comparison indicates by how many times or by what percentage one group differs from another or a standard.

It is important to keep in mind that overall health might improve at the same time that disparities are increasing.

■ **Standardizing the measurement of disparity is critical for assessing progress toward elimination.**

Healthy People 2010, an initiative of the U.S. Department of Health and Human Services, comprises a set of national health objectives to be achieved in the first decade of the 21st century. One of the two overarching goals of this initiative is the elimination of health disparities among segments of the population. Disparities can be measured based on differences by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation. However, no specific definitions or methods for measuring disparity were provided by the originators of Healthy People 2010. Uniform

guidelines for measuring disparities will facilitate consistency and accuracy in the analysis and interpretation of data. (See: <http://www.healthypeople.gov/data/midcourse/default.htm#pubs> for more information.)

“There are good practices [for measuring health disparities] and bad practices. Too little attention is paid to this.”

— Dr. Kenneth Keppel

An illustration of how critical uniform measurements are: in November 2005, the *New England Journal of Medicine* printed Dr. Keppel's response to a previously published article that had indicated a decline (based on absolute measures and favorable events) in health disparities between blacks and whites in the Medicaid population. Dr. Keppel reanalyzed the data using different measurements (relative measures and adverse events) and found just the opposite. When relative measures were used, the reductions in disparities became increases, and two of the disparities were actually quite large. This shows that how disparities are measured affects the results; inconsistent measures lead to inconsistent results.

■ **Disparity cannot be eliminated until there is a clear definition of what it means to eliminate a disparity.**

In just the past few years, much progress has been made in thinking about disparities and creating a consistent way to measure them. Specifically, we can now define disparity; measure it; measure changes in disparity; and compare differences in disparities across indicators.

But, we still cannot eliminate disparities. There is not yet a definition of what it means to eliminate a disparity because there's no definition of parity. Said differently, “What are the criteria that distinguish parity from disparity?”

“So the business of measuring disparities in Healthy People 2010 is unfinished until we can define what it would mean to eliminate disparity.”

— Dr. Kenneth Keppel

Other Important Point

- **Establishing uniformity.** The report *Methodological Issues in Measuring Health Disparities* discusses six issues that affect the measurement of disparities in health between groups in a population. (See: http://www.cdc.gov/nchs/data/series/sr_02/sr02_141.pdf.)

Strategies for Prevention of Gonorrhea and Chlamydia: Achieving Common Understanding

Speaker: **Stuart M. Berman, MD, ScM**, Chief, Epidemiology and Surveillance Branch, DSTDP, CDC

Overview

From incarceration to poverty to racism, the social determinants that impact STD disparity rates in African-American communities are numerous and complex. Public health organizations seeking to reduce disparities would do well to partner with community activists promoting social justice causes. Their goals intersect, and so should their campaigns. Activists can bring passion to STD prevention, framing it as a social justice issue.

Context

Dr. Stuart Berman outlined strategies for engaging the community in reducing gonorrhea and chlamydia transmission rates among African Americans.

Key Learnings

- **At the public health level, standard approaches to STD prevention should take into account the social determinants of health disparities.**

Public health organizations have multiple mechanisms in place for tracking and reducing the transmission rates of gonorrhea, chlamydia, and other STDs in African-American communities. Surveillance, prompt diagnosis and treatment, partner management, screening, and behavioral interventions are the traditional approaches. However, these approaches are limited in effectiveness if they are pursued in isolation and without regard for the particular needs and realities of the communities they serve.

A wide range of social determinants make African-American communities particularly susceptible to STD disparities and represent underlying causes of their high STD transmission rates. These determinants relate to a community's incarceration rates, age composition, levels of education, income levels, segregation, unemployment, racism, sexual mixing patterns, rates of concurrent sexual partners ("concurrency"), health care quality, health care access, and substance abuse.

- **At the community level, STD transmission rates can be lowered by mitigating epidemiological determinants.**

A high community prevalence of STDs can be accompanied by a high prevalence among one's partners and a high risk of contracting STDs, regardless of one's own "risk profile."

For example, nationally representative seroprevalence data showed that in the case of genital herpes, African-American women with a history of two to four partners had a greater than 50% chance of having herpes themselves. White women

with the same number of partners had a less than 20% chance. African-American women with one partner had a greater than 30% chance of having herpes compared with a less than 10% chance for white women with one partner. Populations with a reasonably low risk still had a high rate of infection.

The best bet for African-American communities to reduce STD rates at the population level is by undertaking approaches that would mitigate epidemiological determinants of STD transmission, e.g., number of exposures, probability of exposure, and duration of infection.

"It behooves the community to say, 'How do we make a difference so that life is a bit safer and you don't pay such a price?'"

— Dr. Stuart Berman

- **Each social determinant boosting STD rates acts through at least one epidemiological determinant.**

From the perspective of the "average" infected individual, three epidemiological determinants affect the community's risk. These are the number of "susceptibles" exposed, the probability of transmission given exposure, and the duration of infection.

All social determinants of sexually transmitted disease act by influencing one or more of the epidemiological determinants. For example:

- ▶ In African-American communities, the social determinants of incarceration and divorce/separation disrupt relationships. If the primary male partner is in jail or no longer living in the household, this can lead to the epidemiological risk of more exposed "susceptibles" if the female partner seeks out other sexual mates.
- ▶ Attitudes regarding personal hygiene (for example, douching) are another social determinant that could increase the probability of transmission, given exposure.
- ▶ The lack of access to health care has an effect on duration of infection. If an individual is not treated effectively, or at all, the longer the infection and the higher number of "susceptibles" potentially exposed.

With this understanding it makes much sense for public health departments to broaden their scope to include social causes. Likewise, community activists should take up the STD prevention banner and try to address epidemiological risk factors in their communities. Indeed, their goals are aligned, and each has much to gain from the other.

▪ **Community activists can bring passion to STD prevention by intersecting those goals with social justice causes.**

There is often not passion for STD prevention, but there is deep passion for other societal issues that are related to STD prevention. This includes issues such as empowerment of women, institutional racism, opportunities for youth, and reproductive justice. What those who care deeply about STD prevention must do is link STD prevention to the passion that is focused on these related issues.

For example:

- ▶ Empowerment of women could be related to the idea that sexually active women of color should know that their health depends on being tested annually for chlamydia and gonorrhea. Increased screening could result in shorter duration of infections.
- ▶ Those who are passionate about institutional racism could be motivated to assure quality care that is acceptable to young African-American males, especially those with symptoms.
- ▶ Opportunities for youth are addressed when youth are provided with the skills, knowledge, and self-respect to better protect themselves from acquiring STDs.
- ▶ Reproductive justice is serviced by conveying to those who are infected that it is irresponsible and unacceptable for them to have sex while contagious.
- ▶ By tapping into these larger societal issues, passions and attentions can be brought to bear on STD prevention that would not otherwise have been possible.

▪ **The usual approaches to STD prevention can be made more powerful through collaboration at local levels.**

Typical approaches to STD prevention, which can work with strong community involvement and support, include:

- ▶ *Surveillance*: This includes case reporting to track community rates for different diseases. Community health officials need to be held accountable for doing this tracking and monitoring and answerable to affected communities.

- ▶ *Clinical services—screening*: Annual screening for gonorrhea and chlamydia used to be fundamental, but with decreased rates, widespread screening is no longer recommended. Community advocates for women’s health should push for screening for all sexually active women younger than 25, especially women of color.
- ▶ *Clinical services—access to prompt, high-quality care*: This is especially a problem for young males. Communities need to deal with approaches to make care available.
- ▶ *Partner management*: Systems and programs need to be improved to assure treatment of infected partners. There may be a way for community organizations to facilitate achieving this objective.
- ▶ *Behavioral interventions*: This includes education and communication programs in a variety of settings to encourage and facilitate risk reduction.

“Communities have to take the first step; they have to decide to act.”
— Dr. Stuart Berman

Suggested Actions

Public health organizations can:

- **Mobilize**. Encourage activists to develop a “passion” or cause for eliminating STDs in their communities.
- **Engage**. Share information with communities regarding STD prevalence, and explain how these data are tracked.
- **Collaborate**. Develop strategies for intersecting social justice causes with STD prevention at the community level.

Hearing from Us: Voices of Community Youth About STDs and Sexual Health

Moderator: **Dázon Dixon-Diallo, MPH**, President, SisterLove

Overview

The experiences of people with STDs are often overlooked by health care providers, public health departments, and policy-makers. Yet the realities of affected people's lives must inform any discussion addressing STD disparities among African-American communities. Policymakers have much to learn from this important voice as intervention strategies are developed, especially in the areas of prevention education and outreach as well as access to care and treatment.

Context

Ms. Dázon Dixon-Diallo, Founder and President of SisterLove, moderated a panel of three young, college-educated African-American women who discussed their personal experiences with STDs and reproductive health services.

Key Learnings

- **Peer-led outreach and treatment programs are well received by young adult target audiences.**

STD outreach and treatment programs must be designed with the patient uppermost in mind. It is therefore important to know how to reach people with an STD, how to encourage them to get screened, and how to help them navigate through the treatment process. The best way to capture that information is by listening to the people who have experience with STDs.

"We never listen to the folks who are living the [STD] experience every day."
— Dázon Dixon-Diallo

Women in the late-teen/young adult age bracket are more likely to get screened for STDs and seek treatment if a friend suggests the idea or even accompanies them. Knowing that, SisterLove has launched an innovative program called Community PROMISE that focuses on providing HIV/AIDS prevention education for women attending historically Black colleges and universities (HBCUs) in Atlanta, Georgia. The program enables communities of college-age women to identify issues and risk factors that affect their risk for contracting HIV and other sexually transmitted infections. SisterLove works collaboratively with young women to document their stories and learn how they have made positive choices that enhance their lives. These women then serve as role models and peer educators for other young women in similar circumstances.

Panelist volunteers wholeheartedly endorsed this program as a positive intervention strategy. They concurred that existing peer-led programs should be strengthened, and the peer model emulated by STD-burdened communities without such programs.

- **The health care delivery system works best when the patient has a strong, open relationship with her provider.**

Patients are dependent on health care providers as their primary source of information on STDs and options for prevention and treatment. Panelists who had open lines of communication with their providers reported greater understanding of their conditions and were generally more satisfied with their care. For example, one panelist was grateful to receive a cell phone call from a college clinic nurse asking her to come into the clinic to discuss an abnormal pap smear. Those with less personal contact with health care providers and clinic staff felt more confused.

Interpersonal communication between provider and patient strongly influences health behaviors and decisions. When considering communication strategies to address disparities, it is important to educate and train providers on how their relationships with patients can lead to more effective STD interventions.

- **Treatment must be holistic and address mind, body, and spirit.**

Treatment centers routinely collect sensitive sexual history information, which can be embarrassing for young women to relinquish. When that information is never discussed with the patient, not used to help her in any way, she can leave the clinic feeling her privacy was violated for no good reason.

Although bacterial STDs are easily treatable in the physical sense, the emotional treatment component shouldn't be overlooked given that the stigma associated with STDs can provoke shame. Shame, confusion about the test result, a sense of violated privacy or dignity, not being respected, and a gamut of other negative emotions associated with the screening/treatment experience can impact upon one's sense of self-worth, which can be fragile for African American women in this age group.

The panel generally agreed that mental health must be integrated into STD treatment plans. One panelist reported that she is still struggling mentally with the HPV diagnosis she received several years ago. After getting a prescription from a clinic, she was sent on her way. Information on support groups would have been helpful to this young woman.

Treatment should be personally tailored and sensitively delivered by culturally competent, nonjudgmental providers and staff. A holistic approach is necessary, one that doesn't overlook the mental toll of the disease.

"Mental health does not have to be an afterthought. It has to be integrated into every single thing we do."

— Audience Participant

Other Important Points

- **Bacterial versus viral.** The panelists indicated that general attitudes of young African Americans are very different concerning bacterial and viral STDs. Viral STDs (such as HIV) are seen as serious and lifelong, whereas people believe that with a bacterial STD you simply take a pill and a few days later the infection is gone. Most people are unaware of the potential long-term risks associated with bacterial STDs.
- **No advocacy group.** Ms. Dixon-Diallo pointed out that there is no built-in advocacy group focused on the issues related to bacterial STDs, such as securing funding and political attention.
- **Partner education.** The panelists, who had differing experiences in terms of the education they received from providers, noted that they didn't receive any guidance or resources on educating their partner.
- **The less educated.** Participants noted that the women on the panel all were educated, took the initiative to get screened and gain information, and had the courage to openly discuss their situation. However, many people who have STDs are not as educated and won't take the same initiative. This further complicates the problem of addressing STD disparities.

Communicating Health Disparities: Health Communication with Special Populations

Speaker: **C. Ashani Turbes, PhD**, Investigator, Southern Center for Communication and Poverty (at Macro International, Inc.)

Overview

Effective, strategic health communication is critical to eliminating racial health disparities. Research among African Americans reveals insights around strategies and approaches that can engage African Americans and deliver the right messages in a way that they will be well-received and found credible.

Context

Dr. C. Ashani Turbes of Macro International, Inc., a public health and policy research firm, shared insights from research projects on effective health communication strategies for reaching African-American audiences with STD-related messages.

Key Learnings

- There is no singular “black community.” The black community is a diverse one.

Those in the black community and those who have worked with the black community are aware that this is not a singular, homogenous group. Rather, the African-American community in the U.S. has multiple segments, such as urban and rural, middle class and poor, heterosexual and homosexual. Communication must be tailored to the segment targeted.

- Research studies among poor African Americans in the South shows that STDs are at the forefront of people’s minds.

Macro International and/or the Southern Center for Communication, Health & Poverty (a CDC Center of Excellence) conducted six research projects among poor/near poor (with annual incomes of \$35,000 and less) African Americans in the South. These were studies on: genetics; adolescent smoking; multiple risk factors; preconception health; black women and mass media; and STDs, including HPV (using focus groups).

Several themes emerged from these projects. This demographic group has STDs/HIV on their minds; even in focus groups on unrelated topics, participants expressed concern about STDs. There is a strong stigma and a perception of shame associated with STDs. There were perceptions of racism in and a general distrust of the health care system, but overall trust in a person’s doctor.

“STDs are at the forefront of people’s minds.”
— Dr. C. Ashani Turbes

- Research reveals important communication strategies

for delivering health messages to African Americans.

Framing the communication to deal with issues of trust, shame, and personal responsibility is critical. In addition, it is important to consider all STDs together instead of compartmentalizing them. Among the communication strategies that need to be considered are:

- ▶ *Using trusted messengers:* The messenger is as important as the message. Focus group participants said they rely heavily on family and friends for health information. They also trust faith and community leaders and celebrities (e.g., actors and music artists). Tapping these trusted resources can help influence targeted audiences.
- ▶ *Tapping people who resemble the target—demographically and experientially:* When receiving information about a specific health condition, focus group participants said they want it from someone “like me.” This means people both from the same culture and with the same or similar disease.

“We want to hear [health-related] messages from people like us.”

— Dr. C. Ashani Turbes

- ▶ *Enlisting health care providers:* Because individuals trust their doctors, patient-provider communications are an important way to educate and deliver critical health messages.
- ▶ *Using the Internet and radio:* The Internet and “Black” radio are reliable, powerful communication tools in reaching African-American audiences. When asked “Where do you get health information?,” focus group participants almost *always* mention the Internet. Do not overlook interactive computer-based media such as discussion forums (e.g., Comprehensive Health Enhancement Support System, or CHES).
- ▶ *Using television:* Television is also effective for reaching black audiences. Research shows that television is a powerful way to communicate health information, especially to minority audiences.

- Engage the community for effective communication.

The community has and can provide deep knowledge of the target’s culture and value system. It can be a powerful resource for exchanging information, building trust, and gaining an appreciation of the health issues in a community.

“We must work collaboratively with communities experiencing disparities to overcome the historical context of distrust...”
— Dr. C. Ashani Turbes, quoting Friemuth & Quinn

Workgroup Overview – Objectives and Process

Speakers: **Roxanne Barrow, MD, MPH** and **Lori Newman, MD**, Meeting Co-Chairs, DSTDP, CDC

Overview

An important motivation for this consultation was the creation of workgroups to formulate strategies for eliminating STD disparities by focusing on specific actions to be taken by individual/community members, health care providers, non-governmental organizations/churches/foundations, and government/policy/other structural levels. The groups formed for this consultation will meet regularly over the course of the next year.

Context

Meeting Co-Chairs Drs. Barrow and Newman explained the structure, purpose, and desired output of the workgroups.

Key Learnings

■ On Day 1, the workgroups addressed strategies to reduce STD disparities for each groups' designated intervention level.

The four workgroups each included 12-15 external consultants, representing a diversity of expertise and perspectives on the particular intervention level of the group to which they were assigned (community members, providers, churches/NGOs, government). The groups also included four to six consultants from the CDC's Division of STD Prevention.

Each workgroup was asked to focus on specific tools/strategies for eliminating STD disparities as they developed action steps for their assigned level of intervention:

- ▶ **Workgroup A—Individual and Community Members.** This group was directed to identify how screening, media, and partner services could be implemented to reduce STD disparities.
- ▶ **Workgroup B—Health Care Providers.** This group's efforts concentrated on screening, health care access, and behavioral change interventions that could be developed for physicians and other providers.
- ▶ **Workgroup C—Non-Governmental Organizations, Churches, and Foundations.** Health care access, partner services, behavior change, and media were the tools that this group was to focus on.
- ▶ **Workgroup D—Government, Policy, Structural.** This group was asked to consider all of the aforementioned strategies and any others, from a policy perspective.

All four workgroups were instructed to describe their action steps—including what specific activities they might entail—as well as barriers and facilitators to implementation of these steps, and to provide potential solutions to these barriers.

■ On Day 2, the workgroups were tasked with how to operationalize the strategies decided upon.

The focus was to operationalize the strategies that the groups had recommended by tackling the following questions:

- ▶ Which strategies should be prioritized?
- ▶ How should the selected strategies be framed and communicated?
- ▶ Who should be involved and who should lead these strategies? What can meeting participants do to facilitate and ensure the successful implementation of each strategy? What can CDC do? Who else should be brought in?
- ▶ How should progress on these strategies be measured?
- ▶ How should the workgroup function in the future?

Moreover, the consultants decided operational details related to the workgroups' structure and procedures going forward, and they committed to relaying the information from their groups to their organizations.

■ Their efforts were guided by overarching principles.

Before splitting into their workgroups, Dr. Barrow encouraged the consultants to keep in mind five "must-do's" that Dr. Fenton, NCHHSTP Director, views as incumbent upon health policymakers and others forging STD prevention efforts:

1. We must expand the public health paradigm to tackle the social determinants of ill health within our communities; we must get out of our comfort zones.
2. We need to create a new dialect about sexuality and sexual health for the African-American population—one not bound by perceptions or barriers about what we can achieve.
3. We must promote culturally-competent interventions, building upon traditional approaches, which should inform all of our efforts.
4. We must continue to work with our partners outside of the federal government to meet our common goals.
5. Conceptually, we must move from the general to the specific—translate general principles into specific actions.

■ Group rapporteurs presented the strategies in report-out sessions to the general conference audience.

In report-out sessions following each day's workgroup meetings, rapporteurs elected by the groups summarized the strategies decided upon, including barriers and benefits to implementation of those strategies and specific operational solutions for implementing them. The pages that follow summarize each group's discussions and output.

Workgroup A: Individual/Community Members

Overview

This workgroup discussed three areas of interventions to lower STD prevalence at the community level: 1) increasing STD screening, achieved via community outreach, expanded screening, and mentoring programs; 2) leveraging the media in various ways to get the word on STDs out to individuals; and 3) expanding and improving partner services. Importantly, for these strategies to succeed they must be finely tuned to their target audiences. Also mentioned as critical to success: collaborative efforts among stakeholders, community buy-in, comprehensive services, and cultural competency.

Context

The members of Workgroup A discussed appropriate STD elimination strategies at the community and individual levels.

Key Learnings

■ More STD screening is pivotal to lowering STD prevalence among African Americans.

Workgroup members concurred that more STD screening must occur to curtail the high prevalence of STDs in African-American communities. Screening strategies included:

- ▶ *Conduct community outreach and education.* This initiative would include increasing community awareness of STDs; encouraging individuals to be tested; and using educational contact with members of at-risk populations (such as in incarcerated or recently released individuals) as an opportunity to screen individuals while they are “captive audiences.” Ideas discussed included mobile screening units (like those that have been effective for HIV screening) and community centers where people could go for a range of services besides screening—for example, social, educational, and health-related services.

“In terms of community outreach, we took a page from the HIV prevention strategies implemented over the last several years.”
— Rapporteur

- ▶ *Develop and expand screening guidelines.* The group sees value in relationship-based testing guidelines as well as guidelines with specific criteria for men—to fill the void that seems to exist in STD information targeted at men.
- ▶ *Facilitate mentor opportunities.* Mentor programs where men encourage other men to be tested and programs where fathers and sons come together for STD education were two of the suggestions for increasing screening via mentorship.

■ The media should be leveraged to get STD prevention messages to communities that stand to benefit from the information.

The media is critical in tackling STDs. A media strategy could include the following components:

- ▶ *Identify key community leaders who can help promote the cause, and solicit their buy-in.* The right leaders are critical—efforts should be made to ensure that they hold relevance for the target populations. And their buy-in is vital—they must support increasing community awareness of STDs.
- ▶ *Input from those who have had STDs.* One way to get input is to conduct focus groups with individuals who currently have or have had an STD, and ask them questions about what would have helped them before, during, and after their STD-related experience. This information can be used to inform and guide prevention campaigns.

“One point that became clear to us is that the individuals impacted by these diseases really need to be involved in the solutions. ... Who would know better what’s needed?”
— Rapporteur

- ▶ *Influence programming and other media content to increase STD awareness.* Advocating for screenwriters and journalists to integrate STD issues into TV program and print media storylines could be an effective way to heighten awareness of the issue.
- ▶ *Facilitate creative competitions—leveraging the power of user-generated media.* Encouraging youth to participate in talent contests and creative competitions, to express what they feel and think about STDs and have their voices heard. Winning selections could be highlighted in local or national public awareness campaigns.

■ Improving partner services is a key part of a comprehensive campaign to lower STD rates in a population.

Partner services efforts could include:

- ▶ *Make partner services more comprehensive.* Partner services efforts should address issues such as incest and abuse, include mental health services, and incorporate services for couples. A family-centered approach to service delivery is important to make sure the family is prepared for all the issues that might arise. “Partners” should be broadly defined to include same-sex couples.

“Abuse is a very real situation when it comes to STDs, and we want to be sure to address that.”
— Rapporteur

- ▶ *Expand services for men.* Activities include ensuring that men's services are on par with those of women (participants noted that this is rarely the case), and incorporating services that address intimate partner violence.
- ▶ *Research into partner services issues.* This research could compare various models of delivery and should be constructed to identify the specific types of services most needed in various locales.

■ **There is not one African American community, but many intertwining ones; understanding them is pivotal to helping them.**

Several overarching points emerged as the group grappled with how best to effect community-level changes that will make a difference on STD prevalence:

- ▶ *Realize that African-American communities in America are not homogeneous.* They consist of many sub-communities with differing behaviors and attitudes toward the health care system, sexual risk taking, protecting one's own health and that of the community, STD screening and treatment, and many other issues surrounding sexual health. Cookie-cutter approaches to reaching them all will not work.
- ▶ *Reward desired behavior.* Some groups will resist engaging with those trying to help them unless they see a direct tangible benefit—a reward of some sort that's more real to them than helping the community by being tested.

"We need to leave resources behind so there's some sustainability."

— Rapporteur

- ▶ *Do your social marketing research homework.* In working with community members, it's important to understand the people you are trying to help—understand them culturally and their perspectives, attitudes, and beliefs. This is instrumental in determining what services will most assist them and how to present information to influence them. STD-related messages must be tailored to their specific intended audience or they simply will not get through. Conducting market research is key.

■ **Collaborative efforts, community buy-in, cultural competency and greater accountability are critical.**

Other ideas—many involving roles that various stakeholders could play in STD prevention campaigns—emerged:

- ▶ *The importance of collaborative efforts.* Outreach efforts should involve a wide range of stakeholders: service providers, public health departments, community advocates, faith leaders, educational leaders, and—importantly—STD-impacted residents. The group emphasized the importance of partnerships between health officials and external organizations to jointly provide a range of comprehensive services.

"We're 25 years past cultural consciousness; we should have cultural competency."

— External Consultant

- ▶ *The necessity of community buy-in.* Engaging the community would be pivotal to many objectives, such as reducing the stigma surrounding STDs. Getting community members to take up the STD prevention cause and promote awareness within their circles of influence could mean they aid the effort in a variety of ways, for example, by helping identify target audiences. The STD issue should be framed holistically, as a matter of general health and wellness, which is a justifiable concern of the community.
- ▶ *Greater accountability.* The group favored measures to hold public health organizations more accountable for providing services in culturally competent ways.
- ▶ *The role of the CDC.* The CDC should help bridge the gap from research to practice and mandate the level of services that would best meet communities' needs. CDC should also frame STDs as a public health issue with a degree of urgency associated. It could also provide tool kits for STD prevention campaigns.

Workgroup B: Providers

Overview

Screening, access to care, and behavioral changes are intervention strategies that can be implemented by providers to combat STD disparities. Physicians can facilitate increased STD screening by advocating for improved screening reimbursement. They can persuade individuals to access care by educating communities about available STD services. In addition, they can leverage their authority to promote behavioral change by becoming more involved in their communities.

Context

The members of Workgroup B discussed action plans for implementing specific STD intervention strategies at the provider level.

Key Learnings

■ **Physicians can facilitate increased STD screening by advocating for reimbursement of screening costs.**

The consensus was that lack of reimbursement is a huge barrier to STD screening in African-American communities. A recommended action step was for providers to advocate for the reimbursement of screening costs.

The group cited several barriers to this action step:

- ▶ Its time-consuming nature in the context of limited physician-patient face-time.
- ▶ The challenges of keeping physicians motivated to stay the course year after year.
- ▶ That sometimes STD screening is a tough sell, not always needed or warranted.
- ▶ The community misperception that providers are merely trying to make money.

The cited benefits of this action step were:

- ▶ Increased STD screening.
- ▶ Improved STD diagnoses and treatment.
- ▶ Heightened awareness of STDs in the health community.
- ▶ Leveraged authority of providers in the community.

The cited solutions to effect this action step were:

- ▶ Eliciting support from medical organizations, such as the AMA and NMA, to take the lead on advocacy.
- ▶ Involving drug companies for help with resources.
- ▶ Lobbying for more support from Federal Qualified Health Centers (FQHCs).

The group suggested that the leaders in physician advocacy could be physicians and national health organizations, such as the American Medical Association. The initiative could be supported by drug companies, politicians, public and private hospitals, national HIV organizations, and the community at large. Health departments could possibly offer incentives to physicians who screen for and treat STDs.

Doctors should be equipped with the information needed (advocacy training) to intelligently address legislators on this issue, the group conceded. A representative from the CDC stated that it would be appropriate to consider changing the language in the Comprehensive STD Prevention Systems (CSPS) guidance document to address the financial burden of providing widespread screening.

If the initiative to engage providers in advocacy is adopted, the impact could be large. Success could be measured by the:

- ▶ Implementation of policies by national organizations.
- ▶ Number of providers hosting events to encourage advocacy.
- ▶ Creation of best practices and coalitions in physician advocacy.
- ▶ Creation of a comprehensive catalogue of national organizations that can also participate in the initiative.
- ▶ Responsiveness of insurance companies in reimbursing for STD screening.

There is no need to reinvent the wheel when mobilizing physicians in this effort; advocates can capitalize on existing STD prevention efforts, particularly HIV. National, state, and local campaigns can also be developed to augment these action steps with region-specific activities.

■ **Physicians can educate their communities about services available, thus facilitating access to care.**

The group agreed that educating the community regarding the availability of STD services would help facilitate access to care. A recommended step was for providers to improve their community's knowledge of locations providing STD services.

The group identified several barriers to this action step:

- ▶ Uncertainty about how to establish community-provider relationships.
- ▶ The efforts of special interest groups opposing STD prevention messages.
- ▶ The setting of unrealistically high expectations for the community.
- ▶ The siphoning of funds from other important issues.
- ▶ Potential lack of interest due to stigma surrounding STDs.

The benefits of this action step were seen as:

- ▶ Building relationships and trust between community and providers.
- ▶ Creating awareness of the availability of STD services.
- ▶ Promoting men's responsibility for their own sexual health.

The solutions cited to implement the action step were:

- ▶ Providing accurate data about STD prevalence.
- ▶ Developing culturally-appropriate educational materials.
- ▶ Improving health literacy.
- ▶ Capitalizing on other successful resources.

The group acknowledged that health departments at the state and local levels should take the lead in disseminating information about STDs and available services in African-American communities. Community-based organizations, university medical centers, and the CDC could also assume lead roles. Support could come from those national organizations already engaged in issues surrounding public health, such as the National Association of County and City Health Officials (NACCHO), the National Alliance of State and Territorial AIDS Directors (NASTAD), the Centers for Medicare & Medicaid Services (CMS), CDC, and various syphilis coalitions.

"When I go to my beauty shop ... there is an STD newsletter that tells me all the clinics to go to, what the cost is, and a little information about STDs."

— External Consultant

The group believed this initiative was achievable, and the impact would be large. Success would be measured by the number of information campaigns launched by health departments and the prevalence of STD testing messages, such as "Don't delay! Go today!" The messages should be framed as both sexual and reproductive health issues.

STDs do not exist in a vacuum. The group envisioned providers' taking the lead by encouraging their patients to be screened and treated for STDs. Community-based organizations would conduct initial baseline surveys and follow-ups to determine the percentage of persons being tested for STDs as a result of public health information campaigns.

■ **Physicians can be catalysts of patient behavioral change by becoming more involved in communities.**

The group accepted that providers have the potential to influence patient behavior and promote healthy behavioral change. A recommended action step was that providers themselves become more involved in the community.

The group cited the following barriers to this action step:

- ▶ The effectiveness of what community partners can achieve.
- ▶ The fact that knowledge does not always equal behavior change.
- ▶ The difficulty of framing the message properly and maintaining consistency.
- ▶ In some communities, a lack of current relationships with leaders.
- ▶ The time-consuming nature of these efforts.
- ▶ In some communities, distrust of "establishment" messages.
- ▶ Lack of interest on the part of the provider.

The action step's benefits were identified as:

- ▶ Buy-in from the community that will help motivate behavior changes.
- ▶ Possible involvement of politicians.
- ▶ Increase in testing and diagnoses of new cases.

The solutions identified were:

- ▶ Conducting presentations and seminars in the community—at schools, churches, etc.
- ▶ Providing peer education/lay person education and educating people outside the medical community.
- ▶ Focusing on men's health and the recruitment of men in relaying the message to the community.

Community coalitions, medical organizations, youth groups, community health centers, and medical schools should take the lead in this initiative, with their efforts supported by the CDC, public health departments, drug companies, and other organizations acting in the interests of public health.

Providers will be instrumental in crafting culturally-appropriate health messages that "speak" to the communities they serve. They can also participate in health fairs and share data with their communities regarding the prevalence of STDs. In addition, providers can provide community members with "pre-packaged" STD messages for the community in the form of PowerPoint slide presentations, brochures, and other communication vehicles.

Despite the best efforts of providers, however, the group believed the impact of this initiative would be only moderate. Whatever success is achieved will be measured by conducting physician and community surveys. An increase in the percentage of screening and treatment in the community will be a barometer that providers are getting the word out and their communities are listening.

Workgroup C: NGOs/Churches/Foundations

Overview

A comprehensive response to STD disparities in African-American communities requires the commitment and collaboration of state and local health departments, federal agencies, policymakers, national non-governmental organizations (NGOs), community-based organizations (CBOs), and faith leaders. Many of these groups are already working independently to address this issue. By joining forces and forming coalitions, these groups can take collective ownership of the situation and can leverage their financial and human resources to address STDs and disparities efficiently and effectively.

Context

Workgroup C participants—comprised of external consultants from NGOs, churches, and foundations—developed an action plan for addressing STDs and disparities through local coalitions.

Key Learnings

Local coalitions with national oversight should be mobilized to address STD issues.

There are many national and local entities with a vested interest in decreasing STD occurrence at the African-American community level, and decreasing STD disparities. But when organizations act alone, they have less clout to effect change.

The workgroup sees the key strategy that needs to take place is the formation of coalitions to drive policy changes, secure funding, and execute programs at a local level, possibly through organizations like grassroots health advisory councils.

- ▶ *Coalition participants:* The idea entails formation of coalitions involving multiple stakeholders at both the national and the local level. Participants would include CDC/DSTDP, national organizations, pharmaceutical companies, NGOs, state and county health departments, foundations (private and corporate), churches, and other interested stakeholders.
- ▶ *Leadership and administration:* After getting all of the interested parties to the table, they must agree on one entity to take the lead, and another organization to manage the funding. Governance must be dealt with by defining how the coalitions work. A memorandum of agreement should be drafted to outline these details. It is also important to assign an agent to take fiduciary responsibility.
- ▶ *Goals:* The goals of such coalitions would be to increase community awareness regarding STDs, deliver one consistent and cohesive message, drive changes in policy, secure additional funding, and use funds more efficiently by avoiding duplication of efforts.

- ▶ *Communication:* The workgroup concluded that the best way to frame and communicate this strategy is by creating a national oversight committee that would establish guidelines and speak with one voice. It would provide guidelines and direction to local affiliated organizations, which would act on this guidance at the local level.
- ▶ *Advantages:* Formation of such coalitions offer many advantages. Among other things, coalitions could:
 - Create a unified voice for STDs, which would be louder and more consistent.
 - Reach a broader audience, as messages would be disseminated to the members of all participating stakeholders.
 - Provide more credibility and clout.
 - Increase political power by offering better access to policymakers and influential decision-makers, which would increase the likelihood of getting listened to.
 - Provide economies of scale and cost-efficiency, conserving resources for each member organization.
 - Provide media attention and public profiles that member groups may not be able to achieve alone.
 - Offer access to greater expertise by calling on a range of organizations and individuals.

"Coalitions provide strength through one unified voice."

— External Consultant

Political leaders must be engaged, so they can drive policy changes.

Local, state, and federal elected officials, as well as community stakeholders such as school boards and civic associations, respond to public opinion. They must be engaged in STD disparities elimination efforts so that they appreciate the importance and urgency of responding to this issue in their communities and take ownership for it.

While it is important to get the buy-in of black political leaders, all political leaders must be engaged. The issue must not be framed just as an issue affecting African Americans, but as a broad public health issue.

Importantly, those engaged with political advocacy must hold political leaders accountable. Both national and local organizations must not be content with nice words from politicians; they must demand action and must track and measure progress (which requires dedicated resources for this effort).

"Politicians need to be educated about the problems and be held accountable."

— External Consultant

■ **A key priority among community-based organizations should be a men's mentorship model.**

There is a critical need to engage young African-American men in a conversation about responsible sexual behavior. Hip hop and other pop icons—and their messages of misogyny, promiscuity, and sexual conquest—must be countered by positive role models who deliver positive messages about African-American men and model responsible sexual behavior.

One way to do this is through mentorship. Components of an effective mentorship model include securing community buy-in; identifying trusted, influential role models; and developing

a core curriculum or tool kit of educational information to be used by mentors in affected communities. Educational information needs to focus on health habits such as screening, education, and personal sexual accountability, along with advice on navigating the health care system. Such efforts will certainly require funding and resources. Successful mentoring programs will require additional service capacity to provide screening for men.

While not without controversy, faith-based organizations might be important leaders in launching an outreach and education campaign.

"African-American men have a moral responsibility to take charge of their sexual health."

— External Consultant

Workgroup D: Government/Policy/Other Structural

Overview

Addressing STD disparities among African Americans, and the underlying social problems that cause them, requires that policymakers be informed on the issues and that they take action.

Recommendations from this workgroup for prompting action include calling on CDC to make STD disparities a greater priority and to link efforts around HIV and STDs; forming a multi-agency taskforce to educate policymakers; and convening interagency forums and partnerships to address the underlying social issues that lie at the heart of STD disparities.

Context

This workgroup discussed strategies and action steps for the government and policymakers. The group was comprised of participants from the federal government, non-profit organizations, city/local government, the judicial system, and academic institutions.

Key Learnings

■ **A call-to-action letter will be sent to CDC officials requesting a statement and funded action response.**

To increase the awareness at and to prompt greater action by CDC, a letter will be sent to Drs. Gerberding and Fenton from a group of external partners and concerned parties represented at this consultation. The letter will reference CDC material documenting the racial disparity of STDs and will call for a greater response to this problem from the CDC, both in word and action. Among the actions desired by CDC is a clear statement regarding the role that inequality plays in creating and perpetuating disparities in STD/HIV, and a statement of the steps that will be taken immediately to address fundamental causes.

"The national STD disparity is a national embarrassment."

— External Consultant

Along with being sent to selected CDC staff, the intent is that this letter and call to action will be released to major and minority media outlets as an attempt to raise awareness of the issues surrounding the disparity. One goal is to emphasize that HIV and STDs are not separate issues but are closely related, and that STDs in a community are indicative of multi-layered social issues (incarceration rates, education, racism, poverty). In light of the combination of factors that contribute to the STD disparity, each item cannot be dealt with in a vacuum exclusive of the others.

"We need to make sure that people understand that HIV and STDs are not two separate things."

— External Consultant

Besides raising awareness and promoting action at CDC, the aim of the publicity is to engage political leadership.

Other considerations for this action item are:

- ▶ **Overcoming potential obstacles:** There exists the potential for STD disparities to be viewed as a "silo" issue instead of the cross-cutting issue that it is, and for the solution to be viewed narrowly as one where public health professionals focus on eliminating STDs in a community without tackling the underlying social and cultural problems that perpetuate STDs. Engaging partners around the social issues (i.e., economics, education, 100% high school graduation) and publication of white papers to further define the issues will expand attention on the issue and increase pressure for an adequate response.
- ▶ **Required resources:** Organization of workgroup members without CDC support and a timeline will be needed to prepare and publish the letter and orchestrate the surrounding publicity efforts.
- ▶ **Evaluating impact:** The letter's initial impact will be measured by the response of CDC and other partners, the extent and effectiveness of community activities, and the extent of media attention it generates. Without success in this initial action, the other two action items will not achieve full success.

■ **The group wants to see a multi-agency task force to educate policymakers on STD disparities.**

A large audience (policymakers, educators, elected officials, community leaders, government agency representatives, and health care providers) must be educated on the data about STD disparities that demonstrates that STDs are representations of larger community inequalities and that health disparities require community-based, not individual, solutions.

Furthermore, the interrelationship between STD and HIV transmission must be effectively communicated.

"If you don't address STDs, you will see more HIV cases."

— External Consultant

For achievement of the overall goal, the underlying issues must be clearly understood. The workgroup sees the key to developing that understanding as a high-profile, multi-agency task force. This taskforce should include CDC leadership, other federal agencies, non-governmental organizations (NGOs), and private industry.

Other considerations for this action item are:

- ▶ *Overcoming potential obstacles:* If the appropriate audience is not engaged and the message is not properly conveyed by the media, there is a twofold risk: African-American communities may be further stigmatized; and the perception that other groups are excluded from the initiative may be generated. To avoid either scenario, messages must be skillfully crafted, audience-sensitive, and delivered by a spokesperson who garners the respect of the target audience and has the ability to partner with the media. Understanding by policymakers that integration of programs is a cost-effective way of approaching STD disparities may help programs to gain momentum.
- ▶ *Required resources:* A clear plan and direction are needed, as well as leadership and organization to unite diverse groups. Education and publicity will require monetary support; one method for obtaining this support will be to demonstrate the long-term benefit to HIV prevention, which begins in STD prevention.
- ▶ *Evaluating impact:* With policymakers properly educated, a large societal impact is possible as STD disparities garner attention as a national emergency indicative of larger social/economic/cultural issues. Achievement would be measured through change in STD rates at community level; increased funding for cross-cutting programs and community organizations; and delivery of a consistent, unified message.

■ **Interagency forums and partnerships should also be developed.**

Forums and partnerships must be formed at the federal level that include state and local representation to address the underlying social issues that drive the high rate of STDs in African-American communities. Though possibly spearheaded by a CDC Division, support by other federal agencies would be necessary—such as corrections, justice, education, and labor, to name but a few.

The recurring theme of STDs as a symptom of a national public health emergency must be communicated; without this understanding, simply treating the symptom will not prevent its return. Uniting those with shared interest in solving social problems is a natural first step in a long-term project.

Other considerations for this action item are:

- ▶ *Overcoming potential obstacles:* It may prove difficult to garner political will and break down silos, as traditional silos are easier for individuals and groups to manage. With respect to joint efforts, joint funding would be necessary and may become a cumbersome undertaking for top agency officials. To combat this, it would be necessary to identify strong representatives from each agency and from the start, clearly define each role, responsibility, and expected action to address the disparity.
- ▶ *Required resources:* Political will is essential for a unified venture such as this. Clear, obtainable objectives for each agency are needed (e.g., an initiative with Department of Corrections for routine, opt-out screening). Success in educating policymakers and joint funding initiatives would both be critical to the success of the collaboration.
- ▶ *Evaluating impact:* If successful, this action step could have a large, long-term impact. Initially measured by the ability to convene a meeting and construct a joint plan agreed upon by all participants, the later success of the program would be evidenced by rates of high school graduation, health outcomes, employment, arrests, health disparities, and substance abuse.

Other Important Points

- **Program integration.** There may be a benefit in CDC's considering reintegration of HIV and STD programs—if not complete integration of CDC Divisions, at least a new way of working together.
- **Tearing down silos.** Moving away from the silo effect brings forth low-cost ways to begin to address STDs. If HIV screening is occurring in a community, urine-based STD screenings that do not require examinations should be taking place in the same venue.
- **Jail and prison health.** Health of incarcerated populations must be addressed. If states offer screening for everyone, that should include those incarcerated. Investing in behavioral prevention education and training, though politically controversial, may benefit individuals upon release, thereby benefiting the community in which they live.
- **Campus health.** School and college health must be addressed. School health programs need renewed passion. Success of the 100% high school graduation goal is an important step in addressing health disparities.

CDC's Heightened Response to the Ongoing Crisis of HIV/AIDS Among African Americans

Speaker: **Madeline Y. Sutton, MD, MPH**, Team Lead, Minority HIV/AIDS Research Initiative (MARI), DHAP, NCHHSTP, CDC

Overview

The disparity of HIV/AIDS between African Americans and whites has led the CDC to issue a call to action to address this problem. Doing so has garnered increased attention to this issue and has resulted in identifying best practices to decrease the disparity, which include community mobilization, clear screening recommendations, and increased funding and training for minority researchers.

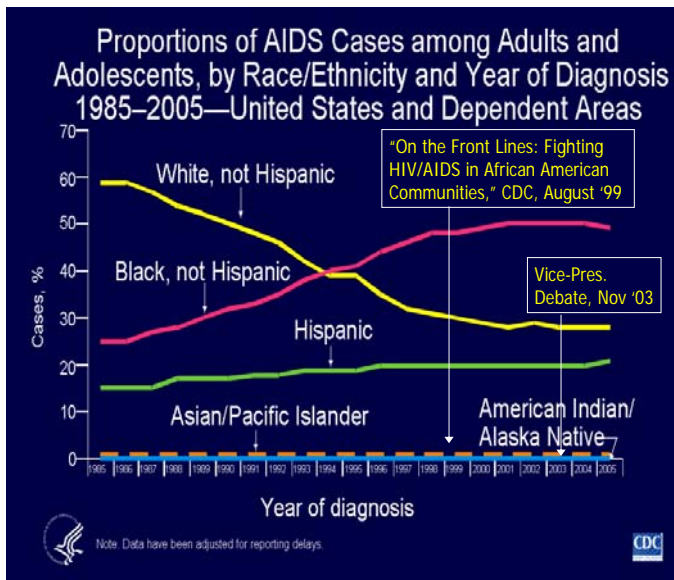
Context

Dr. Sutton presented a synopsis of lessons learned from the CDC's response to the disparity of HIV/AIDS in African Americans.

Key Learnings

■ Awareness of the HIV/AIDS disparity has led to creation of a national agenda to address HIV/AIDS among African Americans.

At the start of the HIV/AIDS epidemic in the mid-1980s, the proportion of AIDS cases among African Americans was about 25%, and white/non-Hispanics represented almost 60% of all AIDS cases. But over the last 20 years, the proportion has shifted. Now whites account for just 25% of all AIDS cases, and blacks account for almost 50%.



In the Vice Presidential debate of 2004, the candidates were queried on their plans to address the significant increase of HIV/AIDS among African-American women, but neither candidate had an answer. This served as a wake-up call for public health officials to put this issue on the national agenda and to address it. CDC has responded in several ways:

- ▶ It has held a series of meetings and roundtables to discuss the issue, and future consultations and meetings are planned.
- ▶ In January 2006, a "Dear Colleague" letter was sent from the CDC Director to health departments, community-based organizations, and traditional and non-traditional partners on the need to focus on the HIV/AIDS epidemic in African-American communities.
- ▶ Dr. Fenton required that everyone at CDC who was involved with HIV-related projects take an inventory of those projects to look at their objectives, the funding, how long the projects had been underway, and what percentage of participants were in high-impact communities, specifically African-American or Hispanic. This inventory process was mind-changing for many at CDC.
- ▶ CDC has also acknowledged the need for and begun work on expanding the reach of prevention with new, effective interventions, increasing opportunities for diagnosing and treating HIV, and mobilizing broader community action by engaging community leaders.
- ▶ A Heightened National Response to HIV/AIDS was launched on March 8, 2007, at a meeting led by CDC Director Dr. Julie Gerberding. This meeting focused on securing commitments from leaders on the progress that could be made in one year.

■ "Best practices" from the CDC's HIV/AIDS initiative: community mobilization, clear screening recommendations, and researchers to whom targets relate.

Three key learnings that can help in formulating strategies to combat bacterial STDs in African-American communities have emerged from programs to combat HIV/AIDS:

- ▶ *Mobilizing community leaders is critical.* The Heightened National Response calls upon African-American leaders to "ACT"—which stands for "Awareness," "Communication," and "Testing":
 - **Awareness** begins as community leaders break the silence within the community by talking about HIV/AIDS where people live, work, play, and worship. The hope is that their honest communication and willingness to be

involved will change community perception surrounding HIV/AIDS—challenging the stigma, encouraging healthy behaviors, and assisting in motivating people to seek early HIV diagnosis and treatment.

- **Communication**, continuous and open communication, is critical for collaboration to flourish. Knowledge of partners' activities, resources, and needs; sharing information and points of contact; and establishing a timeline will aid all members of the collaboration to focus on the same goals. CDC plans to publish and distribute information on the social factors contributing to the HIV/AIDS epidemic among African Americans and effective interventions to address these factors. CDC will provide technical assistance to state and local health departments, as well as education and guidance to faith leaders on ways to initiate dialogue and encourage awareness, involvement, and behavior change. To ensure a true collaboration, reporting and follow-up will occur.
- **Testing**. Community leaders should partner with community organizations that serve African Americans in an effort to link clients to relevant prevention programs and testing services. Leaders should urge community members to understand the importance of regular screening.
- ▶ *Articulate, clear screening recommendations.* In 1985, at the beginning of the HIV/AIDS epidemic, HIV testing was available on a voluntary basis. Soon after, risk-based counseling and testing was performed in STD clinics, and in 1993 voluntary testing was available in non-STD healthcare settings. But targeted, risk-based screening missed a substantial number of infected, pregnant women, and in 1995 counseling and voluntary testing was provided for all pregnant women.

In 2003, universal screening began in pregnant women as well as rapid testing during labor and delivery. *Revised Recommendations for HIV Testing for Adults, Adolescents and Pregnant Women In Healthcare Settings* was published in September 2006, recommending that all persons aged 13 to 64 receive HIV testing as a routine part of medical care. The advantages of this approach: 1) by significantly increasing the number of persons tested, fewer infected people should “slip through the cracks” and more diagnoses should be made earlier; and 2) routine testing decreases barriers to testing both for providers and the patients—there is no need for the provider to determine risk based on the patient's behavior, and there is no embarrassment for the patient in having to request the test.

One idea that was presented is to develop one set of screening recommendations for all STDs (both bacterial and viral) that is furnished to all health care providers.

“Keep it straightforward. Let's get to screening anyone who is sexually active.”

— Dr. Madeline Sutton

- ▶ *Researchers who are culturally and demographically similar to target populations get better results.* To address gaps in HIV epidemiologic and prevention research in African-American and Latino communities, and to fund junior researchers who demonstrate the skills to conduct HIV/AIDS research in these communities, the Minority HIV/AIDS Research Initiative (MARI) was established at CDC in September 2003. The program grew out of data demonstrating that people are more open with personnel and staff with whom they can identify—i.e., people who look, sound, and act like them. HIV/AIDS affects African Americans and Latinos disproportionately, so this finding highlights a need to increase the number of African-American and Latino researchers within the community. As a result, MARI seeks to increase the number of HIV/AIDS researchers who self-identify with at-risk populations.

Lessons Learned from STOP TB in African American Communities

Speaker: **Nickolas DeLuca, PhD**, Chief-Education, Training and Behavioral Studies Team, Division of TB Elimination (DTBE), CDC

Overview

The number of tuberculosis cases in the U.S. has been on the decline, but not the disparity between blacks and whites. CDC, in partnership with individuals and groups from various public and private organizations, has undertaken initiatives to address the TB disparity problem. The midpoint evaluation of partners in a one-year project shows promise that effective measures have been adopted and are being implemented. While these initiatives are early, they are showing good progress.

Context

Dr. Nickolas DeLuca shared the background and preliminary results of a multi-agency summit to eradicate TB in African-American communities.

Key Learnings

■ While TB cases in the U.S. have declined overall, racial disparities have not improved.

The belief by some people that TB has been eliminated is far from correct. While overall rates of TB continue to decline in the U.S., the disease still exists and strikes racial and ethnic minorities disproportionately. In 2005, 82% of all reported TB cases occurred in racial and ethnic minorities, with 45% of all cases in African Americans (who represent just 13% of the U.S. population). The TB case rate among African Americans is 8.9 per 100,000, more than eight times that of whites, which is 1.1 per 100,000.

Both HIV/TB co-infection rates and disparities remain significant. The TB/HIV co-infection rate is 18% in blacks compared with a 6% rate among whites. Alarming, 31% of those with TB have an unknown HIV status, this despite the fact that since 1989 CDC has recommended HIV testing for all TB patients, and in 2006 it released revised recommendations for routine, voluntary HIV screening to occur in all healthcare settings. Fortunately, once in TB treatment, blacks have a treatment completion rate similar to that of whites, near 85%.

"TB is not a disease of the past. It is here and is a disease characterized by significant health disparities."

— Dr. Nickolas DeLuca

■ Health officials focused on the TB disparities problem through meetings in 2003 and 2006.

In 2003, CDC and the Advisory Council for the Elimination of TB (ACET) convened a national meeting of like-minded participants to raise awareness of the continuing disparity

of TB among blacks in the U.S. The goals were to expand collaboration among stakeholders and identify actions addressing the TB disparity issue. (The ACET is a federal advisory council that provides advice and recommendations regarding TB elimination policies, strategies, objectives, and priorities to HHS, CDC, and Division of TB Elimination.)

To further expand partnerships built in this initial meeting, a summit was held in May 2006 with participants from CDC, HHS, professional associations, academic institutions, and local and national advocacy associations. The goals of this summit were to raise awareness of the problem and to create links and build networks to lead to ongoing strategies to address the problem. During this summit, participants were grouped with peers from similar organizational types to identify action items that could be completed within one year with no additional funding from CDC.

"We would love additional resources, but we can't wait for those resources to address this topic."

— Dr. Nickolas DeLuca

■ Summit participants' actions to date point to successful partnerships, heightened awareness, and increased political will.

Approximately five months after the May 2006 summit, a preliminary evaluation took place. To date, the following steps have been taken:

- ▶ *Education and awareness:* CDC educational materials have been distributed at exhibits and health fairs, to community-based organizations, and in professional organization conference packets. Distribution of the *TB Challenge* newsletter has increased. A website and listserv for TB in African-American communities have been established.
- ▶ *Networking:* TB programs have made new contacts with local programs and with state and regional HHS Minority Health Consultants. Collaboration and communication among CDC divisions have increased. New partners have been engaged, such as concerned black clergy and minority health consultants.
- ▶ *Capacity building:* TB in African Americans is now included in the CDC TB Program Manager's Course. Local training includes awareness of the topic, and organizations are including TB topics as sessions at conferences.
- ▶ *System change:* Local-level changes have been reported, such as increased access to care, increased availability of testing, and integrated TB/HIV services and education. Surveillance measures have been adjusted to distinguish between TB in U.S.-born blacks compared with all blacks.

- ▶ *Publicity:* Publicity vehicles have included post-summit presentations and posters, articles, and links on partner websites.
- ▶ *Political will:* For the first time, the 2007 National TB Controllers Association Meeting includes a breakout session about TB in African Americans. The Tuberculosis Epidemiologic Studies Consortium (TBESC) has funded a multi-year, multi-million-dollar epidemiologic study on early diagnosis, prevention, and treatment of TB in the African-American community.

The summit successfully rekindled dialogue and interest between traditional partners and engaged new partners to join in working on the problem of the disparity of TB in the African-American community.

"The summit was very beneficial in putting TB on our radar screen... Before the summit, we were not doing anything in TB."

— National Advocacy Group Participant

A second round of follow-up will occur. To ensure continuity across programs, participants will be consulted on best practices to assist in completion of unfinished action items. Communication is expected to be ongoing via the listserv and website for all agencies and individuals interested in this topic. (See: http://www.cdcnpin.org/scripts/listserv/tb_aa.asp.)

Lessons Learned from Syphilis Elimination

Speaker: **Virginia A. Caine, MD**, Director/Associate Professor of Medicine, Marion County Health Department, Indiana University School of Medicine, Division of Infectious Diseases

Overview

Through a comprehensive and well-coordinated syphilis elimination strategy, Indiana's Marion County (which includes the city of Indianapolis) dramatically lowered its syphilis rates, which had been the highest in the country, and decreased its disparity. The strategies employed, like expanded clinical services and health promotion, and the lessons learned are applicable broadly.

Context

Dr. Caine presented an overview of Marion County, Indiana's successful syphilis campaign, offered insights on the program, and shared lessons learned that might inform efforts to address STD disparities nationwide.

Key Learnings

■ **Marion County's story demonstrates that efforts to reduce STD cases and disparities can succeed, even in the most difficult of situations.**

In 1999, Indianapolis led the country in the number of syphilis cases, with 407. At that time, the population of Marion County was 75% white and 23% African American, but African Americans accounted for 94% of all syphilis cases. The African American-to-white ratio for cases was 77:1.

Surveillance data showed that there were certain "hot zones" in the poorest areas of the county, where syphilis rates were as high as 468 per 100,000. These were also areas with high concentrations of drug use and prostitution. Many were federally designated Medically Underserved or Health Professional Shortage Areas. In hot zones, 40% of primary and secondary syphilis cases were linked to crack cocaine use and prostitution. In 1998, just prior to the height of the epidemic, the median age of those with syphilis was 31 years; three years later the median age had shifted downward, and it was the young adult (ages 20-24 years) and teen (ages 13-19 years) populations with the highest percentage of cases.

Though the situation seemed bleak, and many challenges were encountered over the next few years, public health professionals in the area took the problem seriously and determined to make their communities healthier. Their commitment paid off, as syphilis in Marion County decreased from 50 cases per 100,000 in 1999 to fewer than three cases per 100,000 in 2003; by 2006 only 43 cases were reported, and the African American-to-white case ratio had decreased to 1.3:1.

■ **Lowering the rate of syphilis—and the disparity—**

required specific elimination strategies and plans.

Among the challenges faced in reducing/eliminating syphilis were provider-related issues such as understanding where those with STDs go for care, assuring that health care personnel had adequate knowledge about syphilis, and understanding the components of how health providers establish trust with STD patients. A challenge was how to market syphilis elimination messages while not perpetuating the stigma associated with syphilis. And perhaps the most important challenge was to shift the perception of syphilis as an African-American issue to a public health issue.

Addressing these challenges involved the following syphilis elimination strategies:

- ▶ *Enhanced surveillance:* Eliminating syphilis starts with having the data so that interventions can be appropriately targeted. In Marion County surveillance went beyond simple case counts to pinpointing the location of each case. By geocoding cases, it was discovered that 60% were within three zip codes, and public health agencies were able to target resources in these areas.
- ▶ *Community involvement and organizational partnerships:* Partnerships involved enlisting the support of political leaders, including Indianapolis's mayor and sheriff, as well as federal, state, and local agencies. Partnering also meant creating a coalition of 78 organizations, including faith-based organizations, and providing significant funding to support community-based organizations. Among the most important lessons learned were the power of communities in syphilis elimination and the recognition that grassroots leaders and key laypersons are community assets and are necessary allies in building community coalitions.
- ▶ *Rapid outbreak response:* This meant having resources that could be deployed to go to where those who were infected were located to find and treat them. For example, outreach took place in frequently-visited locations such as beauty shops, barber shops, and laundromats.
- ▶ *Expanded laboratory and clinical services:* Addressing syphilis required creating adequate access to health care for those who were infected. That meant keeping clinics open evenings and weekends. Also, since many individuals in the hot zones were unwilling or unable to travel to health clinics, officials brought clinical services to these individuals. Screening and testing facilities were established in close proximity to areas where sex workers operated; mobile vans were sent into the community to offer food in exchange for syphilis testing; and hang tags were placed on the door-knobs of people's houses announcing dates when the screenings would be offered in the community.
- ▶ *Enhanced health promotion:* Several promotional efforts

took place to increase syphilis awareness, with professional marketing firms consulted to ensure the effectiveness of the campaign. Most notable was the Stamp Out Syphilis (SOS) campaign, which used all types of media, especially billboards and bus placards. Health fairs were held in malls and schools that included contests and game shows with STD-related questions, SOS dancers and dance contests, and a basketball tournament that required players to correctly answer an STD-related question before participating. All the efforts were designed to engage the target audience and to create trust by communicating at appropriate venues using the right language.

Other important elements of the elimination efforts in Indiana included educating health care providers about syphilis and developing a mechanism (e.g., focus groups and surveys) for patient input regarding interventions and programs.

■ **The lessons learned in Marion County are applicable broadly.**

The key lessons learned include:

- ▶ *Strong leadership is mandatory.* Eliminating syphilis is hard work. It requires support from all levels of the government, the local community, and the health care system. It requires funding, resources, and active promotion. All of these elements require strong, committed leadership.
- ▶ *Knowledge of the disease is essential for everyone involved.* Before Marion County's SOS campaign, not only did individuals lack knowledge about STDs but approximately 25% of medical practitioners failed to correctly diagnose STDs. The health department did not have adequate knowledge to treat syphilis. Therefore, a key lesson is the need to educate the health care community.

mechanism (focus groups and surveys) for patients to provide input regarding syphilis elimination programs and interventions.

- ▶ *Resources must be available.* Financial support and competent staff are necessary for a successful campaign. Facilities to support the cultural needs of diverse populations and substance abuse treatment must be funded, staffed, and accessible.

"No matter what anybody tells you, it takes resources. We spent over \$1 million a year addressing syphilis... [Without] that money, we probably would still be working on the syphilis epidemic."

— Dr. Virginia Caine

- ▶ *Broad societal issues must be addressed.* Poverty, substance abuse, unemployment, presence of working poor, lack of education, and low health literacy all adversely impact syphilis elimination efforts. Tackling syphilis ultimately requires addressing all of these issues.

"You have to address substance abuse in your community if you're going to address STDs."

— Dr. Virginia Caine

- ▶ *There must be a blueprint and clear direction.* Collaboration between persons and organizations at all levels of government must occur with agreed-upon goals.

- ▶ *Patient input is necessary.* Marion County developed a

Next Steps: Where Do We Go From Here?

Moderator: **Walter W. Williams, MD, MPH**, Associate Director for Minority Health, Office of the Director; Director, Office of Minority Health and Health Disparities, CDC

Speakers: **John Douglas, MD**, Director, DSTDP, CDC

Overview

Although the racial disparities in STD prevalence in America today clearly represent a health care crisis, STD prevention initiatives face multiple obstacles, ranging from the lack of health insurance for a large portion of American society, and a majority of those most at risk, to funding cutbacks at the federal level, to state legislative impediments. This consultation, however, has laid important groundwork, conceptually and operationally, for an initiative that can make a difference in the lives of affected people. Critical to success is collaboration within and between the CDC and other stakeholders.

Context

DSTDP Director Dr. John Douglas gave the meeting's closing remarks that covered: 1) points of clarification on issues raised by conference attendees related to the government's progress on the STD prevention front; 2) a recap of key learnings from the meeting; and 3) a description of where CDC envisions the STD disparities elimination effort going from here.

Key Learnings

■ **From a national policy perspective, this initiative faces multiple obstacles.**

It has been a decade since the 1997 publication of the groundbreaking work by the Institute of Medicine's Division of Health Promotion and Disease Prevention—*The Hidden Epidemic, Confronting Sexually Transmitted Diseases*. (Several meeting participants referenced this report during the meeting.)

That work's vision was to establish an effective national system for STD prevention by: 1) overcoming the barriers to the adoption of healthy sexual behaviors; 2) developing strong leadership, strengthening investment, and improving information systems focused on the STD problem; 3) designing and implementing essential STD-related services for adolescents and underserved populations; and 4) ensuring access to and quality of essential clinical services for STDs.

Progress has been made in many of these areas, but as this meeting highlighted, much still needs to be done to realize this decade-old vision across all segments of American society.

Why hasn't more been done? The headwinds are daunting:

- ▶ **A huge uninsured population:** According to the Robert Wood Johnson Foundation, 46 million—16% of the U.S. population and 19% of non-elderly people—have no health care insur-

ance. Uninsured ranks correspond strikingly with the age/race/income demographic profile of those most at risk for STDs. The toll on a personal level of not having health insurance is manifest in less likelihood to receive Pap tests, chlamydia tests, or prescription drugs. The toll on society: 18,000 unnecessary deaths and \$65-\$130 billion per year in lost economic value. The estimated annual cost of providing coverage to all of the uninsured ranges from \$34 billion (for public coverage) to \$69 billion (private coverage). Tackling STD prevention among at-risk individuals would be far easier if they were insured.

- ▶ **Decreased funding:** STD programs have less funding than five years ago, while funding for other government programs and health initiatives has soared:

Programs with More Funding	
Strategic Nat'l Stockpile	897%
Terrorism	703%
Global AIDS	575%
Vaccines for Children	84%
Programs with Stable Funding	
Health Statistics	7%
Chronic Disease	3%
Immunization	3%
Programs with Less Funding	
Tuberculosis	-14%
Sexually Transmitted Diseases	-15%
Domestic HIV/AIDS	-17%

- ▶ **Lack of urgency/emergency status:** In response to queries during the conference about why the STD/HIV epidemics among African Americans was not being called a national emergency, with all the actions and media attention that designation would trigger, Dr. Douglas said the issue clearly is an urgent public health problem—calling it a “crisis” would not too be too strong. However, “Public Health Emergency” is a designation with particular legal ramifications and can only be declared by the Secretary of Health and Human Services.
- ▶ **Lack of partner therapy:** There is a solid rationale for Expedited Partner Therapy (EPT), which is delivering treatment to sex partners (by patients, field staff or through pharmacies) so they do not need to make a clinic visit. This would provide public health staff assistance in contacting, notifying, and treating the sex partners of persons infected with many STDs. However, it's not permissible in many

states.

■ **This consultation has laid the conceptual groundwork for an effective response.**

Meeting participants—both in CDC's Division of STD Prevention and external consultants—have come out of this consultation with the following:

- ▶ *Increased awareness:* Raised awareness and knowledge about the problem of bacterial STDs in African-American communities, including the individual, social, and health impacts of these disparities.
- ▶ *Strategies for addressing the issue:* Identification of a range of possible prevention and control strategies on how to address bacterial STDs in affected African-American communities.
- ▶ *Research insights:* Insight about current and future research and funding needs in this area.
- ▶ *Motivation and next steps:* Stimulus to develop an action plan for CDC and key community stakeholders to address STD disparities among African Americans.

■ **Now the operationalizing begins.**

Moving forward, DSTDP, along with external consultants, will use the ideas generated at this consultation as a foundation for identifying and implementing specific strategies to address disparities in bacterial STDs among African-American communities. The next steps in the process include:

- ▶ *Communication: Maintain active dialogue/communication with workgroup participants.* Workgroups in designated areas will be asked to meet at least quarterly by conference call (external co-chair working with CDC co-chair). This summary report documenting meeting content and output, will also aid in short-term communication goals. Ongoing communication will be facilitated by list-servs, workshops, and sessions at STD conferences (e.g., the National Coalition of STD Directors National Conference and the 2008 National STD Prevention Conference), and a web-based conference in one year to discuss the workgroups' progress.

- ▶ *Evaluation: Evaluate how well the consultation's objectives were achieved.* Outcomes of the consultation and implementation of action plans/strategies will be evaluated based on the consultation's short- and long-term objectives (see Meeting Objectives, Session 1).
- ▶ *Collaboration: Collaborate with key community stakeholders /partners on identified opportunities.* Among these should be opportunities to integrate the bacterial STD disparity efforts with those to eliminate racial disparities in other sexual health issues, such as HIV, herpes, and hepatitis B.

■ **Collaboration will be instrumental to success.**

The overriding emphasis of both the short- and long-term objectives of this consultation centered on the need for collaboration. Collaboration must take place between CDC and all stakeholders that share similar or vested interests, such as:

- ▶ Other programs within NCHHSTP (e.g., combating TB and HIV in African-American communities).
- ▶ External partners in public health, academia, and policy.
- ▶ The impacted community, which must be engaged and involved in the process for progress to be realized.

"Whatever we're going to do to succeed in this area has got to be collaborative."

— Dr. John Douglas

Participants' Perspectives

Overview

"Preaching to the choir" was a commonly-heard phrase throughout the meeting, as many attendees called on CDC to "expand the public health paradigm" and "take ownership of the health disparities problem" by adopting objectives outside the usual purview of public health. CDC was asked to take a leadership role in promoting structural reform of those institutions identified as contributors to health disparities, such as the educational system that 31% of African-Americans drop out of and the criminal justice system subject to gross racial sentencing inequities. "Racial health disparities weren't created within the public health system," one consultant said, "and they won't be eradicated by traditional public health interventions."

Context

In discussion and Q&A sessions throughout the meeting, external consultants expressed their views and asked questions of presenters and CDC hosts. This recaps many of the ideas expressed.

Insights

- Lack of political champions.** There is little support on Capitol Hill for increasing the funding of programs to eliminate STD disparities. The increased funding that buoyed the syphilis elimination program's success has not been seen for other STDs. Gonorrhea and chlamydia are "lost issues" on Capitol Hill, with no champions, in contrast to HIV/AIDS. Since health disparities are intertwined with social issues, they should be presented in that context to Washington—bundled with causes like education that do garner legislators' attention. But a barrier to be mindful of is that each issue is siloed in the federal budget.

"You can get people to come to Washington to talk about AIDS; no one wants to talk about gonorrhea."

—Participant

- Education as a health goal.** The 31% drop-out rate of African Americans before completing high school is an important underlying cause of racial health disparities. The African-American drop-out rate is as high as 60% in some cities. Research, such as that by Dr. Adimora, shows high school education to be an STD risk factor. Reforming America's educational system should be a public health goal, with several participants advocating a goal of a 100% high school graduation rate.

"We have to move to eliminate the gross social injustices perpetuating health disparities."

—Participant

- Wider meeting participation.** One speaker asked, "We agree that there are all these social determinants in health, so why as I look through the list of attendees at this conference don't I see experts from education and housing and prison reentry?" She requested that such experts be invited to follow-up meetings.
- The role of CDC.** Several attendees suggested that CDC expand its public health mission and take leadership on the underlying structural causes of health disparities. The reality may be that for political reasons CDC cannot initiate an expansion of its mission, requiring that external forces issue a call to action to broaden CDC's role.
- No shot-gun approaches.** Actions CDC takes along these lines must not be executed in "rifle fashion" but on a sustained basis over time, because these structural impediments to better health "affect everything else you do."
- Remember the gay and bisexual.** Gay and bisexual black men face even greater obstacles than those stemming just from race, as they are also discriminated against because of sexual orientation. STD research seems not to have assessed disparities between white and black men who have sex with men (MSM) or between black gay and heterosexual men.
- CDC trumpeting.** Individuals within CDC cannot lobby Congress, but it is critical that CDC publish papers that highlight its successes. That will help those who can lobby Congress immensely in promoting the causes. "And don't wait," added the speaker.
- Wider involvement of government.** A statement should come out of this effort that calls upon the various governmental agencies with authority over the institutions that contribute to the problem to be accountable for the ways they perpetuate racial health disparities and to respond with appropriate corrective actions. Perhaps the STD disparities issue should be declared a national state of emergency so that other agencies would be forced to respond. A consultant who saw the STD situation declared an emergency in his state said the other agencies were at a loss as to how to respond; the declaration was "just a label." They had no guidelines for how to reallocate resources—perhaps CDC could help in that respect, providing such guidelines. (*Dr. Douglas responded to the national emergency idea in his closing remarks—see Next Steps, Session 19.*)

"[To CDC:] Put the word out there that your job is compromised, that your job can't be done unless the other agencies work with you to respond to this issue."

—Participant

- Sentinel markers of ailing communities.** Discussions about

STD disparities should be framed to highlight that they are sentinel markers of not-well communities—communities without opportunities, self-determination, etc.

- **Criminal justice reform as a health goal.** Likewise, America's criminal justice system, "which acknowledges the existence of gross racial sentencing inequities," should be reformed, and CDC should advocate for such reform on the grounds that current practices represent a public health issue, contributing to the gender imbalances in African-American communities that promote partnering behavior that escalates STD prevalence.
- **Weakest link weakness.** The weakness in the "weakest link" argument for strengthening groups within communities, to the benefit of all, is that different racial groups in America don't view themselves as being on the same chain. So those framing STD messages should emphasize the ways in which Americans are intimately connected with one another.

"They don't acknowledge a common destiny—or a common anything."
—Participant

- **Grass-roots for the picking.** If funding or scholarships could be set aside for small grass-roots organizations advocating for the social causes that would help eliminate disparities, these small organizations would be better positioned to help. Perhaps funding agencies such as NIH and CDC should actually seek out such organizations to support with funds and other resources.
- **Untapped local resources.** On the local level, coalitions of service providers already exist who are trained and engaged in looking at local priorities, local assessments, and local risk factors in order to make recommendations to their local public health departments about allocation of CDC funds. Tapping them would create synergistic efficiencies in terms of both advocacy and capacity-building, a way to integrate programs without creating new systems. Another participant added that some local public health departments give grants to community-based organizations, but that is not well publicized.

- **Integration with HIV/AIDS.** Millions of dollars are being directed to expansion of HIV/AIDS services, yet bacterial STDs are not being addressed among the same population. People should look into what can be done to break down the silos of overlapping epidemics on the local level.
- **National health plan.** Our health care system is in trouble. Large companies laying off employees increases the ranks of the uninsured; the high cost of pharmaceuticals seems to have no solution, as everyone wants effective medicines when they need them; doctors and patients hate navigating insurers' red tape and seeing coverage denied despite hefty premiums paid; and the message sent to the uninsured by our government—your life isn't worth preserving—takes a huge psychological toll. Universal health care coverage alone won't eliminate racial disparities (other countries with such plans still have disparities), but it will go a long way. Health is a human right; STD discussions require a human rights framework.

"[Without universal health insurance,] we are trying to hold back the ocean with a broom."
—Participant

- **The presence of fathers.** Fathers' presence in children's lives can make the difference between their thriving in society and their entering the criminal justice system. Interventions should also focus on promoting family values and restoring the black family unit.

Biographies

Summary 1 Meeting Objectives

Deidra Parrish, MD, MPH & TM (moderator)

*Post-meeting Liaison, Division of STD Prevention (DSTDP),
Centers for Disease Control and Prevention (CDC)*

Deidra Parrish is currently an Association for Prevention Teaching and Research (APTR) Fellow in the Epidemiology and Surveillance Branch of the Division of STD Prevention, CDC, in Atlanta, Georgia. Her main areas of activity with CDC have included reviewing data around access and acceptability of STD care for African-American communities, developing and assessing STD program performance measures, and evaluation of outreach and clinical services for sex workers in Mali. Prior to her fellowship, she worked on a survey of African-American adolescent girls' knowledge of sexual behaviors and infection, as well as a survey of malaria chemoprophylaxis in pregnant women. She completed a combined residency in internal medicine and preventive medicine at Tulane University Health Sciences Center in New Orleans, Louisiana. She also obtained a Master of Public Health and Tropical Medicine degree from the Tulane University School of Public Health and Tropical Medicine. Dr. Parrish attended medical school at the University of Alabama School of Medicine in Birmingham, Alabama, and obtained a BS in clinical laboratory science from Howard University in Washington, D.C.

John Douglas, MD

Director, DSTDP, CDC

John Munroe Douglas, Jr., MD, is Director of the Division of STD Prevention (DSTDP), National Center for HIV/AIDS, Viral Hepatitis STD and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC). Born in Charlotte, North Carolina, Dr. Douglas earned his BA degree in English, *Summa Cum Laude*, from Davidson College, North Carolina, in 1974 and his MD from Harvard Medical School in 1978.

He completed his internship and residency in Internal Medicine at the University of Washington Affiliated Hospitals in 1981, where he also served as Chief Medical Resident before completing his fellowship in 1984 with the Division of Infectious Diseases, University of Washington Affiliated Hospitals.

Prior to joining CDC in 2003, Dr. Douglas served in a combination of key management, science and medical positions for the Denver Department of Health and Hospitals (now Denver Health).

These include Director of STD Control; Director, Denver Public Health Virology Laboratory; Attending Physician in Medicine and Infectious Diseases, Denver General Hospital (now Denver Health Medical Center); and the Medical Director of the Denver STD Prevention Training Center. Dr. Douglas is a leader in the field of STD prevention, nationally recognized for his contributions in

applied research on the epidemiology and treatment of STDs for the translation of research findings into effective STD prevention program practice, and for effective STD prevention program policy development.

While at Denver Health he also held various academic appointments at the University of Colorado Health Sciences Center. In 1996 he was named Clinical Teacher of the Year for the Division of Infectious Diseases, and in 1999 he was appointed full Professor, Departments of Medicine and Biometrics and Preventive Medicine.

Dr. Douglas is a prolific and significant contributor to the fields of STD and HIV prevention, particularly viral STDs and research on genital herpes and HPV. His publications include over 100 journal articles, mostly in peer-reviewed journals, several book chapters, and more than 150 abstracts.

Dr. Douglas' memberships in professional organizations include the Infectious Diseases Society of America, the American STD Association (for which he served as Secretary-Treasurer and Vice President), the American Social Health Association (ASHA, for which he served as Chair for the HPV Scientific Advisory Committee), and the American College of Physicians.

Kevin Fenton, MD, PhD, FFPH

*Director, National Center for HIV/AIDS, Viral Hepatitis, STD,
and TB Prevention (NCHHSTP), CDC*

Kevin Fenton, MD, PhD, FFPH, is the Director of the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC). In November 2005, Dr. Fenton was named Director of the National Center for HIV, STD and TB Prevention, which was renamed NCHHSTP in March 2007 to reflect the addition of CDC's Viral Hepatitis program. He joined CDC in January 2005 as Chief of the National Syphilis Elimination Effort, leading a revitalization of this program to end the sustained transmission of syphilis in the United States.

Prior to his work at CDC, Dr. Fenton was the Director of the HIV and Sexually Transmitted Infections Department in the United Kingdom's Health Protection Agency (HPA). At the HPA, he established England's national chlamydia-screening program and led the development of the European Surveillance of Sexually Transmitted Infections (ESSTD) network, a 25-nation collaboration to enhance STD surveillance and prevention throughout Europe.

Dr. Fenton has served in a number of academic and community leadership positions and has consistently focused on addressing racial and ethnic disparities in sexual health. Beginning in 1995, he was a lecturer in HIV epidemiology at the Royal Free and University College Medical School in London, where he also

directed a research program on Migration, Ethnicity, and Sexual Health. In 1998, Dr. Fenton was appointed senior lecturer and honorary consultant epidemiologist at the HPA's Communicable Disease Surveillance Centre. And in 2002, he established the African HIV Research Forum to advance the response to HIV in the UK's African communities. Prior to arriving in the U.S., Dr. Fenton served as an advisor to a number of European Union government and charitable organizations.

Dr. Fenton has published numerous book chapters and peer-reviewed articles on HIV and STD epidemiology, policy and sexual behavior, with a special emphasis on racial and ethnic health disparities. His works have been published in prominent journals including *The Lancet*, *Sexually Transmitted Diseases*, *AIDS*, the *British Medical Journal*, and the *Journal of Infectious Diseases*.

After graduating from the University of the West Indies Medical School in Jamaica in 1990, Dr. Fenton earned his Masters in Public Health at the London School of Hygiene and Tropical Medicine in 1993. He earned his PhD from University College London in 2005 with a thesis on race, ethnicity, and the epidemiology of STDs. Dr. Fenton is a Fellow of the Faculty of Public Health of the Royal Colleges of Physicians of the United Kingdom.

Summary 2 Epidemiology of STDs in African-American Communities

Lori Newman, MD
Meeting Co-Chair, DSTDP, CDC

Lori M. Newman is a medical epidemiologist with the Division of STD Prevention at the CDC in Atlanta, Georgia, and a medical officer in the U.S. Public Health Service. She received her BA in geography from Dartmouth College and her MD from the University of California San Francisco.

Dr. Newman completed her residency in Family Medicine at the University of Washington in Seattle, WA, and the Epidemic Intelligence Service in Atlanta, Georgia.

Her current areas of interest include racial/ethnic disparities in STDs, surveillance for gonorrhea and other STDs, gonorrhea treatment, and the translation of surveillance data into program activities. She is the project officer for the STD Surveillance Network (SSuN) Project, and the Outcomes Assessment through Systems of Integrated Surveillance (OASIS) Project. Dr. Newman also provides technical support to the Mozambique National STD Program and the CDC Global AIDS Program office in Mozambique. Dr. Newman provides clinical care to patients at the North DeKalb Grady Community Health Center and maintains a faculty appointment at the Emory University School of Family Medicine.

Summary 3 Framework for Understanding Disparities

Beny J. Primm, MD
Executive Director, Addiction Research and Treatment Corp.

Dr. Primm has been the Executive Director of the Addiction Research and Treatment Corporation (ARTC) of Brooklyn, New York since its inception in 1969, one of the largest minority non-profit community based substance abuse treatment programs in the country.

Since 1983, Dr. Primm has served as President of the Urban Resource Institute, a non-profit organization that was established to provide supportive social and medical services to critical populations within New York City.

In recognition of his world-renowned authority on HIV, addiction, and AIDS, Dr. Primm was appointed to the Presidential Commission of the Human Immunodeficiency Virus Epidemic in 1987. In that capacity, Dr. Primm represented the U.S. at a meeting of the World Health Organization (WHO), Geneva, Switzerland, and at the International Conference for Ministers of Health on AIDS Prevention in London.

Dr. Primm has served on special committees on drug and alcohol problems for the WHO on several occasions and has represented state and federal governments at special meetings in other European, and African countries, and the Caribbean. He is the chairman of the Board of Directors of the National Minority AIDS Council and is the 1st vice chairman of the National Black Leadership Commission on AIDS.

In 1989 Dr. Primm was appointed by the Secretary of Health and Human Services to direct the federal government's Center for Substance Abuse Treatment (CSAT), formerly known as the Office for Treatment Improvement (OTI).

He is the recipient of numerous awards and in November 2000, was granted the Surgeon General's Medallion for U.S. Public Health Service for his lifetime of leadership in mental health and substance abuse treatment in the battle against the AIDS Epidemic.

August 6, 2003, Dr. Primm was appointed to the Presidential Advisory Council on HIV and AIDS (PACHA). The Advisory Council provides advice and recommendations to the President and Health and Human Services Secretary, on research, prevention, and treatment of people living with HIV/AIDS.

Sevgi O. Aral, MS, MA, PhD
Associate Director of Science, DSTDP, CDC

Dr. Aral is the Associate Director of Science (ADS) for the Division of STD Prevention at CDC. As ADS, Dr. Aral is responsible for the oversight and direction of all scientific activities including the intramural and extramural research programs and science-

program interactions. In addition to her appointment at the CDC, Dr. Aral has served as a professor of sociology in the United States and Turkey. She has served in the role of mentor for both trainees and colleagues needing help with social science perspectives bridging the gap between clinical epidemiology and behavior. She currently serves as a clinical professor at the University of Washington School of Medicine.

Dr. Aral's work has focused on risk and preventative behaviors, gender differences, societal characteristics that influence STD and HIV rates, contextual issues, and effects of distinct types of sexual mixing on STD spread. Her research has been in both domestic and international settings and her writings have included cross-cultural comparative analysis.

Dr. Aral is on the editorial boards of several scientific journals including *Sexually Transmitted Diseases*, *AIDS Education and Prevention*, and *Sexually Transmitted Infections*. In addition she is the Associate Editor of *Sexually Transmitted Diseases* and *Sexually Transmitted Infections*. In the past she has served multiple terms on the editorial boards of *AIDS* and *American Journal of Public Health*.

Dr. Aral received her PhD and MA in social psychology from Emory University and another MA in demography from the University of Pennsylvania. She received her undergraduate degree from Middle East Tech University in Turkey.

Summary 4 Social Determinants of STDs

Adaora Adimora, MD
University of North Carolina

Adaora (Ada) Adimora is an Infectious Diseases physician and Associate Professor of Medicine and Adjunct Associate Professor of Epidemiology in the School of Medicine and School of Public Health at the University of North Carolina at Chapel Hill. She earned her undergraduate degree at Cornell University and MD at the Yale School of Medicine. She did a residency in Internal Medicine at Boston City Hospital and a fellowship in Infectious Diseases at Albert Einstein College of Medicine/Montefiore Medical Center in New York City. After her fellowship she worked as an Infectious Diseases physician at Harlem Hospital. She then moved to North Carolina where she worked at the state health department in the Epidemiology Section's Communicable Disease Control Section as Assistant Chief for Science. She was subsequently recruited to the University of North Carolina School of Medicine.

Dr. Adimora's research focuses on the epidemiology of HIV and STDs among minority populations. She is particularly concerned with behavioral epidemiology and has emphasized the role of sexual networks and the socioeconomic context in heterosexual HIV transmission in this population. She is also interested in the role of structural interventions in eliminating racial disparities in HIV and STD rates in the United States.

Summary 5 Perceptions of Sexuality, Faith and STDs in African-American Communities

Edwin Clifton Sanders, II
Senior Servant and Founder of the Metropolitan Interdenominational Church

The Reverend Edwin C. Sanders, II, is the Senior Servant and Founder of the Metropolitan Interdenominational Church, a congregation that has attracted a broad cross-section of people.

Metropolitan has outreach ministries in the areas of substance abuse, advocacy for children, sexual violence, and harm reduction, in addition to providing services to persons infected with, and affected by, HIV/AIDS through the First Response Center, which Rev. Sanders founded in 1992.

Rev. Sanders is a graduate of Wesleyan University, where he received the Bachelor of Arts Degree in Anthropology in 1969. He specialized in Cultural Anthropology, and his thesis was entitled, "The Black Church as a Revolutionary Institution." Rev. Sanders' professional life also began at Wesleyan, as Co-Director of the African American Institute, and he is a former member of the Wesleyan University Board of Trustees. He has done graduate study at Yale University Divinity School and as a special student at Vanderbilt University Divinity School. The opportunity to travel extensively throughout Europe and Africa was afforded Rev. Sanders as one of the first fellows of the Thomas J. Watson Foundation.

Until recently, Rev. Sanders served as Pastoral Counselor for the Meharry Medical College Alcohol and Drug Abuse Program in Nashville, Tennessee, where he was responsible for the spiritual component of all programs. This work was primarily built around the conducting of group and individual therapy sessions. Also in Nashville, Rev. Sanders has served as Director of the Southern Prison Ministry, and also as the Dean of the Chapel at Fisk University.

Rev. Sanders holds membership in the Nashville Branch of the NAACP, and the Interdenominational Ministers' Fellowship (former President). He is a member of the Alcohol and Drug Council of Middle Tennessee, and has served as a Commissioner for the Tennessee Human Rights Commission. He is past Chairperson of the Ryan White Community AIDS Partnership, and is still an active member of the consortium. In April 1998, he was appointed to the CDC Advisory Committee on HIV and STD Prevention by Donna Shalala, then Secretary of Health and Human Services, where he also served as co-chair of the National Syphilis Elimination Working Group. Rev. Sanders was a presenter at the 12th World AIDS Conference in Geneva, Switzerland, in the summer of 1998, and the 13th, in Durban, South Africa, in the summer of 2000, as well as speaking regularly for conferences and other forums throughout the United States regarding HIV/AIDS and substance abuse issues.

Rev. Sanders serves on the Boards of Directors of the Black AIDS Institute, The National Black Leadership Commission on AIDS, and The Drug Policy Alliance. He is the National Coordinator for Religious Leaders for a More Just and Compassionate Drug Policy, and a member of the National Advisory Council on Sexual Health at the National Center for Primary Care. In 2002, he was appointed by President Bush to serve on the Presidential Advisory Council on HIV/AIDS (PACHA). Also in 2002, Rev. Sanders was a candidate for Governor of the state of Tennessee, finishing third out of a field of fourteen candidates.

He is married to Denise Billye Sanders and has three children: Edwin III, Grace Louise, and Joseph Wesley.

Summary 6 Reducing Health Disparities: Influences and Opportunities in Health Care Financing and Delivery

Yasmin Tyler-Hill, MD

Assistant Clinical Professor of Pediatrics,
Morehouse School of Medicine

Yasmin Tyler-Hill is a board-certified pediatrician who is an Assistant Professor in the Department of Pediatrics at Morehouse School of Medicine and is currently serving as the President-Elect, Medical Staff, Children's Healthcare of Atlanta at Hughes Spalding.

She earned her masters degree at Princeton University; majoring in Biology with a Letter for Sciences in Human Affairs. Her thesis was entitled *Infant Mortality in the United States*. She earned her MD at the Medical University of South Carolina. She completed her residency and her internship at Boston City Hospital in Boston.

Dr. Tyler-Hill received a grant to develop software and clinical guidelines to track at-risk patients as part of a managed-care cost-containment initiative. Her research focused on "Asthma Clinical Tracking for a Medicaid Population in a Teaching Hospital." In addition, she provided a proposal titled, "A Medical Home for ME" to develop a medical clinic for children with developmental disabilities. Her proposal was submitted to The Center on Medicine as a Profession at Columbia University's College of Physician and Surgeons for a fellowship position in advocacy.

Summary 7 Measuring Health Disparities

Kenneth G. Keppel, PhD

Statistician, National Center for Health Statistics (NCHS), CDC

Dr. Ken Keppel is a statistician with the National Center for Health Statistics. He received his PhD from the Pennsylvania State University. For the last seven years he has been working on the measurement of disparities. He led the effort to define

disparity and to measure changes in disparity in Healthy People 2010. He produced a report, *Methodological Issues in Measuring Health Disparities, Vital and Health Statistics, Series 2, No. 141*. He is now concerned with the question: What is parity?

Summary 8 Strategies for Prevention of Gonorrhea and Chlamydia: Achieving Common Understanding

Stuart M. Berman, MD, ScM

Chief, Epidemiology and Surveillance Branch, DSTDP, CDC

Stuart M. Berman currently serves as chief of the Epidemiology and Surveillance Branch in the Division of STD Prevention at CDC. The Branch is composed of over 40 epidemiologists and researchers. The Branch monitors and interprets STD rates across the nation; investigates increases in STDs; informs the nation about the rates and epidemiology of STDs; produces documents of international importance, including the CDC STD Treatment Guidelines; and develops, conducts, and oversees research that has direct and national influence on STD prevention.

Prior to his present position, Dr. Berman served in CDC's Office of the Director, coordinating an effort in collaboration with the National Coalition of STD Directors (NCSDD) to develop a performance management system for the national STD prevention program. In addition, Dr. Berman served as Chief of the Adolescent Activities Unit, where he was responsible for integrating, directing, and strengthening Division activities to prevent STDs and their complications among adolescents in the United States. He is a commissioned captain and senior surgeon in the U.S. Public Health Service.

During his tenure at CDC, Dr. Berman has held several public health leadership positions, including Special Assistant for Perinatal and Adolescent Studies, Medical Epidemiologist, Preventative Medicine Resident and Epidemic Intelligence Service Officer. He has assisted in national, international, epidemiologic and evaluation efforts concerning STD, HIV infection, and maternal and child health. Previous responsibilities at CDC include strategic planning for the Division of STD prevention, development, and coordination of demonstration projects designed to prevent perinatal transmission of HIV, and various studies on congenital syphilis and chlamydial infections.

Prior to joining CDC in 1983, Dr. Berman served as a pediatrician in several clinics in Massachusetts. He received a Master's degree from Harvard School of Public Health, his undergraduate degree from Lehigh University, and a degree in medicine from Albert Einstein College of Medicine. He is board certified in Pediatrics and Preventive Medicine. He has written numerous scholarly publications on STD prevention, screening, treatment, and trends among adolescents.

Summary 9 Hearing from Us: Voices of Community Youth About STDs and Sexual Health

Dázon Dixon-Diallo (moderator)

President, SisterLove

Dázon Dixon-Diallo is Founder and President of SisterLove, Incorporated, the first women's AIDS organization established in the southeastern United States. She also serves as an adjunct faculty member in women's health at Morehouse School of Medicine and Spelman College, and is a recipient of the 2004 Ford Foundation's Leadership for Change Award. Ms. Diallo currently chairs the Fulton County Title I HIV/AIDS Services Planning Council and the Community Advisory Board of the HOPE Clinic, Emory University's HIV Vaccine and Microbicides Research Center. She hosts a weekly radio program focused on black women, "Sistas' Time," on WRFG 89.3FM and www.wrfg.org in Atlanta, and has coordinated delegations of African-American women to Brazil, China, Egypt, Jamaica, South Africa, Senegal, and Uganda. She recently opened a SisterLove program office in Mpumalanga, a rural South African province near Johannesburg, where the project focus is capacity building for local HIV/AIDS organizations. Ms. Diallo holds a master's degree in public health from the University of Alabama at Birmingham and a bachelor's degree from Spelman College in Atlanta, Georgia.

Summary 10 Communicating Health Disparities: Health Communications with Special Populations

C. Ashani Turbes, PhD

*Investigator, Southern Center for Communication and Poverty
(at Macro International, Inc.)*

Ashani Turbes is an Investigator with the Southern Center for Communication and Poverty (Southern Center) and a Project Manager with Macro International Inc. She received her BA in political science from Hampton University and MA and PhD in political science, with a public policy and methods concentration, from Purdue University. Her research interests focus on health disparities, public deliberation/engagement, and quantitative methods for research and evaluation.

Dr. Turbes has over a decade of experience in research design and methodology, evaluation, and data collection and analysis. Her experience blends her academic background in political science and public policy with her work in public health, health communication, and public health.

Summary 11 Workgroup Overview

Roxanne Barrow, MD, MPH *Meeting Co-Chair, DSTDP, CDC*

Roxanne Barrow is a medical epidemiologist in the Division of STD Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the Centers for Disease Control and Prevention and a medical officer in the U.S. Public Health Service. Her current areas of interest include racial/ethnic disparities and quality of care in STD clinics. She serves as a medical consultant to public health departments and other health care professionals in the medical management and prevention of STDs. She also provides patient care at the Fulton County Department of Health and Wellness STD clinic in Atlanta, Georgia.

She received a BA from the University of Rochester. She earned her MD from Meharry Medical College and her MPH from the University of Massachusetts. She completed her residency training in Internal Medicine at Roger Williams Hospital (Brown University Affiliated Hospital) and Preventive Medicine at the University of Massachusetts. She also completed postgraduate training in epidemiology in the Epidemic Intelligence Service at CDC.

Summary 16 CDC's Heightened Response to the Ongoing Crisis of HIV/AIDS Among African Americans

Madeline Y. Sutton, MD, MPH

*Team Lead, Minority HIV/AIDS Research Initiative (MARI), DHAP,
NCHHSTP, CDC*

Madeline Sutton is a board-certified obstetrician/gynecologist who is currently serving as the Team Lead for the Minority HIV/AIDS Research Initiative (MARI) in the Division of HIV/AIDS Prevention at the Centers for Disease Control and Prevention (CDC). Her main research areas at CDC have been in the areas of racial/ethnic disparities in STDs, including HIV, women's health issues, and adolescent health issues. She maintains a faculty appointment at the Morehouse School of Medicine Department of Obstetrics and Gynecology and provides clinical care to patients at the Oakhurst Community Health Center in Stone Mountain, Georgia.

Prior to moving to Atlanta, Georgia to complete her CDC Epidemic Intelligence Service fellowship training, she completed her residency training at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School. She received her MD and MPH degrees from Columbia University and her BS from Georgetown University.

Summary 17 Lessons Learned from STOP TB in African-American Communities

Nickolas DeLuca, PhD

*Chief-Education, Training and Behavioral Studies Team,
Division of TB Elimination (DTBE), CDC*

Nickolas DeLuca is Chief of the Education, Training, and

Behavioral Studies Team in the Communications, Education, and Behavioral Studies Branch, Division of TB Elimination (DTBE) at CDC. Dr. DeLuca has worked in DTBE since 1997. Dr. DeLuca oversees the design, implementation, and evaluation of health education materials, training, behavioral science studies, and health promotion activities. In addition, Dr. DeLuca provides consultation and technical assistance to both national and international TB Programs on education, training, and behavioral studies activities. Dr. DeLuca received his PhD in Health Education and Health Promotion, from the Department of Health Behavior at the University of Alabama at Birmingham. Since March of 2007, Dr. DeLuca has served as Acting Associate Director of the Office of Health Disparities in the National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention.

Summary 18 Lessons Learned from Syphilis Elimination

Virginia A. Caine, MD

Director/Associate Professor of Medicine, Marion County Health Department, Indiana University School of Medicine, Division of Infectious Diseases

Virginia A. Caine, MD is the Director for the Marion County Health Department in Indianapolis, Indiana. She is also an Associate Professor of Medicine in the Infectious Disease Division of the Indiana University School of Medicine. Dr. Caine earned her bachelor's degree from Gustavus Adolphus College in Minnesota and her medical degree at New York Upstate Medical Center in Syracuse. She received her Infectious Disease training at the University of Washington in Seattle. Dr. Caine was instrumental in spearheading one of the most successful community collaborations, the Stamp Out Syphilis (SOS) Coalition, to significantly reduce Marion County's syphilis cases ranking from first in the nation in 2000 to number 40 in 2004. She has served as a consultant on the CDC's "Developing Strategies for Syphilis Elimination in the United States" panel, HIV Testing Implementation Advisory Committee, and MMWR Editorial Board. Dr. Caine is active in several professional societies, including the National Medical Association and the Council on Education for Public Health, and served as a past President for the American Public Health Association.

Summary 19 Next Steps: Where Do We Go From Here?

Walter W. Williams, MD, MPH (moderator)

Associate Director for Minority Health, Office of the Director; Director, Office of Minority Health and Health Disparities, CDC

Walter Williams is the Associate Director for Minority Health, Office of the Director, Centers for Disease Control and Prevention (CDC) and Director of CDC's Office of Minority Health and Health Disparities. He received a BA (Phi Beta Kappa) from Brown University in 1973, and in 1978, an MD and an MPH with a major

in Health Services Administration from Harvard Medical School and the Harvard School of Public Health, respectively. After completing a residency in Internal Medicine at Emory University in Atlanta, he served two years in CDC's Epidemic Intelligence Service in the National Center for Infectious Diseases (NCID), then completed the CDC Residency in Preventive Medicine and Public Health.

Dr. Williams has held a number of leadership positions during his over 20 years at CDC including Chief, Guideline Activity, Hospital Infections Program, NCID; Editor pro-tem of CDC's *Morbidity and Mortality Weekly Report*; Chief, Child and Adult Immunization Section, Division of Immunization, National Center for Prevention Services; Coordinator of CDC's Adult Immunization Initiative; and Chief, Adult Vaccine Preventable Diseases Branch (AVPDB), Epidemiology and Surveillance Division (ESD), National Immunization Program (NIP), CDC.

His previous work has involved developing national guidelines for the prevention and control of hospital-acquired infections, investigative consultations of unusual disease clusters, assembling and editing important local, national, and international public health information, operational and basic epidemiologic research, coalition building with national and community-based organizations, and serving as project officer on a number of public health interventions. As Chief, AVPDB, NIP, he directed epidemiologic and programmatic activities related to vaccine preventable diseases affecting adolescents and adults and implemented prevention and control activities. This work involved a particular focus on under-served, hard-to-reach populations.

Currently Associate Director for Minority Health, he serves as the principal advisor to the Director, CDC/Administrator Agency for Toxic Substances and Disease Registry (ATSDR) on minority health issues and the focal point for minority health programs, projects, and coordination of CDC/ATSDR's minority health activities. He has published extensively and spoken at regional and national symposia on epidemiology, public health, and preventive medicine. He holds faculty appointments at the Morehouse Medical School and the Emory University School of Public Health; is chairman of the Advisory Committee for the Residency in Public Health and Preventive Medicine, Morehouse School of Medicine; and is a diplomate of the American Board of Internal Medicine and the National Board of Medical Examiners. He is a fellow of the American College of Preventive Medicine.

John Douglas, MD

Director, DSTDP, CDC

See Summary 1 for biography.