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

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Both HIV & COVID-19 disproportionately impact communities of color

**HIV**

**THE LIFETIME RISK OF ACQUIRING HIV:**

- **BLACK/AFRICAN AMERICAN**
  - MSM: 1 in 2
  - Transgender Women: 1 in 2
    - Men: 1 in 22
    - Women: 1 in 54
  - **HISPANIC/LATINX**
    - MSM: 1 in 5
    - Transgender Women: 1 in 6
      - Men: 1 in 51
      - Women: 1 in 256
  - **AMERICAN INDIAN/ALASKA NATIVE**
    - MSM: 1 in 12
    - Transgender Women: N/A
      - Men: 1 in 131
      - Women: 1 in 403
  - **WHITES**
    - MSM: 1 in 11
    - Transgender Women: 1 in 6
      - Men: 1 in 140
      - Women: 1 in 941

**COVID-19**

**ELEVATED RISK COMPARED TO WHITE AMERICANS:**

- **BLACK/AFRICAN AMERICAN**
  - Cases: 2.6x higher
  - Hospitalizations: 4.7x higher
  - Deaths: 2.1x higher
- **HISPANIC/LATINX**
  - Cases: 2.8x higher
  - Hospitalizations: 4.6x higher
  - Deaths: 1.1x higher
- **AMERICAN INDIAN/ALASKA NATIVE**
  - Cases: 2.8x higher
  - Hospitalizations: 5.3x higher
  - Deaths: 1.4x higher

(O’Neill Institute, 2020)
COVID-19 is part of a syndemic that magnify health inequities by race

As COVID-19 cases have exploded in the United States, stark racial disparities in incidence and mortality have emerged. The prevalence of COVID-19 among Black and Hispanic communities is higher than among White communities. The lower rates of testing among these communities have been documented. In a study from the CDC, Black and Hispanic persons were less likely to be tested for COVID-19 than White persons. Moreover, disparities in testing rates are associated with differential outcomes. The CDC found that Black and Hispanic persons were more likely to be hospitalized and to die from COVID-19 than White persons. This disparity is associated with socioeconomic factors, such as income, education, and occupation, which are known to be predictors of health outcomes. It is clear that the COVID-19 pandemic has highlighted and exacerbated existing health disparities.

COVID-19 is part of a syndemic that magnifies health inequities by race. This syndemic includes HIV, Hepatitis C, and Opioids. These conditions are interrelated and exacerbate each other, resulting in a complex web of health challenges. The synergistic effect of these conditions leads to worse health outcomes for individuals and communities. It is crucial to address these disparities and provide equitable access to healthcare and resources to mitigate the impact of this syndemic.
• “...while health care accounts for some 10 to 20 percent of the determinants of health, socioeconomic factors and factors related to the physical environment are estimated to account for up to 50 percent of the determinants of health”
Distribution by borough of NYC hospital beds & COVID-19 cases

Queens, 31%
Brooklyn, 27%
Bronx, 23%
Manhattan, 13%
Staten Island, 7%

NYC Hospital bed counts https://profiles.health.ny.gov/hospital/county_or_region/ Categorized by author
Nursing Homes With Relatively High Shares of Black or Hispanic Residents Were More Likely To Have At Least One COVID-19 Death

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

- Facilities with High Share of Black Residents: 63%
- Facilities with Low Share of Black Residents: 40%
- Facilities with High Share of Hispanic Residents: 55%
- Facilities with Low Share of Hispanic Residents: 44%
- Facilities with High Share of White Residents: 37%
- Facilities with Low Share of White Residents: 58%

All Facilities: 45%

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

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

- Black partners
- Current STI dx
- Undiagnosed HIV (HIV+ MSM)
- Lower education
- CD4 < 200 (HIV+ MSM)
- Low income
- Crack cocaine
- HIV status nondisclosure (HIV+ MSM)
- Ever incarcerated
- No health coverage (HIV+ MSM)
- Less ART adherence (HIV+ MSM)
- Not virally suppressed (HIV+ MSM)
- Childhood sex abuse
- Less ART access (HIV+ MSM)
- Early sex debut
- Fewer clinical visits (HIV+ MSM)
- Older partners
- Concurrent partners
- Receptive UAI
- Serodiscordant UAI (HIV- MSM)
- HIV+ partners (HIV- MSM)
- Serodiscordant UAI (HIV+ MSM)
- Injection drugs
- Circumcised
- 1 vs. >1 lifetime HIV tests
- Number of sex partners
- Same race partners
- Serosorting (HIV- MSM)
- Drug use before/during sex
- Gay ID
- Amphetamines
- Amyl nitrates

(Millett, The Lancet, 2012)
We are on track to end the HIV epidemic with White Americans

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

(Zang et al, 2020)
Social determinants of health that magnify health inequities
SARS-COV-2

- Income
- Homelessness
- Unemployed
- Residential segregation
- Insurance/Health care access
- Carceral settings
- Provider bias
- US resident status
- Federal policies

HIV

Millett, JIAS, 2020
Social Determinants of Health & HIV Racial Disparities

Associations with HIV incidence in black communities

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

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

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

Black isolation (RR 54.12, 30.5-95.7)
Homelessness and HIV outcomes may worsen due to the COVID-19 Recession

(Clemenzi-Allen, 2019)
The COVID-19 Recession and Women

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

Employed workers, in millions

<table>
<thead>
<tr>
<th>City</th>
<th>COVID-19 downturn</th>
<th>Great Recession</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May 2020</td>
<td>February 2020</td>
</tr>
<tr>
<td>All workers</td>
<td>137.5</td>
<td>158.0</td>
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<tr>
<td>Women</td>
<td>63.5</td>
<td>75.0</td>
</tr>
<tr>
<td>Men</td>
<td>74.0</td>
<td>83.0</td>
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PEW RESEARCH CENTER

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drop in caseloads are likely to experience a second surge. This pandemic has reinforced important truths: inequities related to social determinants of health are magnified during a crisis, and sheltering in...
COVID-19 and Residential Segregation

Residential segregation plays a role in coronavirus disparities, study finds

(Millett et al, 2020)
As with COVID-19, HIV diagnoses are highest in more diverse counties (fewer whites) and lowest in counties with more white residents.

The centrality of health insurance in health equity

The percentage of uninsured Americans dropped from 2012 through 2017, but EHE locations lagged behind the nation as a whole.
Percent of Uninsured is Highest in The 7 EHE States

Source: ehe.amfar.org
Citizenship Status of Nonelderly Uninsured Population by Race/Ethnicity, 2018

- **White**
  - Non-Citizens: 4%
  - Naturalized Citizens: 10%
  - U.S. Born Citizens: 94%

- **Black**
  - Non-Citizens: 2%
  - Naturalized Citizens: 85%
  - U.S. Born Citizens: 9%

- **Hispanic**
  - Non-Citizens: 6%
  - Naturalized Citizens: 40%
  - U.S. Born Citizens: 50%

- **Asian**
  - Non-Citizens: 47%
  - Naturalized Citizens: 28%
  - U.S. Born Citizens: 25%

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

Factors that increased inequities with higher compared to lower values included proportion of HIV diagnoses due to injection drug use, percent Latino living in poverty, percent not English proficient.
Being uninsured was associated with traveling a greater distance for HIV care. People who travel more than 5 miles for care had 30% lower retention in care (aOR=0.71, 95% CI: 0.58, 0.86) and lower viral suppression. A DC cohort of 3,623 HIV+ participants receiving care. Those traveling ≥5 miles had 30% lower retention in care (aOR=0.71, 95% CI: 0.58, 0.86) and lower viral suppression.
Racism and Racial Attitudes are Associated with Health Outcomes

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

**Abstract**

**Objectives**

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

**Methods**

We collected data from a variety of public available sources for 617 counties in the US. (20% of all counties). Cumulative COVID-19 deaths and cases from January 22 to August 31, 2020 were the dependent variables. Explicit racial attitudes and implicit racial attitudes served as the moderators: subjective poor fair health, food insecurity, percent unemployed, percent incarcerated, median family income, percent women, percent of Asian county residents, percent of Hispanic county residents, and percent of people 65 or older were controls.

**Results**

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

**Conclusions**

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

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Fig 1. Relationships among percent black county residents, explicit racial attitudes, implicit racial attitudes, and COVID-19 cases per 100,000 residents for January 22, 2020 to August 31, 2020. A. Explicit racial attitudes. B. Implicit racial attitudes.
Health inequities are deeply entrenched and costs live as well as resources

The primary hypothesis of this study is that racism and health care impose costs on numerous health care costs and indirect costs such as labor costs conducted three sets of analysis, assessing (1) direct costs, using data from the Medical Expenditure Panel Survey (2002-2006) to estimate the potential cost disparities for racial/ethnic minorities with health inequities for racial/ethnic minorities at a premature death, using data from the National Center for Health Statistics (2003-2006). They estimate that eliminating health disparities would have reduced direct medical care expenditures and indirect costs associated with ill health by about $1 trillion for the years 2003-2006 (2008 dollars) with the values of our society and addressing the social justice issues, but this analysis shows that social justice can address the disparities.

In 2002, the U.S.-based Institute of Medicine report on racial and ethnic inequities in quality of care within health care settings (1). Unequal Treatment placed the issue of racial and ethnic inequities in health status and health care on the nation’s health policy agenda, leading to increased attention and resources devoted to understanding and ultimately solving this longstanding and vexing problem.

Racial/ethnic disparities in health status and health care are well documented (2, 3), mainly using vital statistics to compute differential age-adjusted mortality. How does the scale of this pandemic compare to another US epidemic? using demographic models, I estimate how many excess White deaths would raise US mortality to the best-ever recorded Black level under alternative plausible assumptions about the age patterns of excess mortality in 2020. I find that 4.6 million excess White deaths equal the best mortality ever recorded a mortality in 2020 to reach levels that Black lives have experienced every year. I argue that if this excess mortality is not experienced by a factor of nearly a year, the US mortality is likely to be less than what US Blacks have experienced every year. I argue that if this excess mortality is not experienced by a factor of nearly a year, the US mortality is likely to be less than what US Blacks have experienced every year. This COVID pandemic is likely to be a frontier in a real-world test of mortality in the United States. Yet mortality disparities were highlighted even in mortality for US Blacks in any given year. A recent study has shown that the selection of race in 1919 was lower than the urban school in every documented. Fig. 3 shows that the similar pattern persistent age-adjusted total mortality and life expectancy in 1919 was less than in 2019, yet in the last century, Black in the United States are comparable to White’s experience of the 1919 pandemic. That is, inefficiencies in race of the early twentieth century is a twentieth-century, with a deadly pace for Blacks that consistently mortality in the United States. Despite recent scholar focus on rising White mortality (2), that racial inequities remain unchanged. At fig. 1, I estimate, between Black age-adjusted mortality and life expectancy an equivalence to White mortality from expediency, nearly 20 or 30% higher. For COVID-19 to raise mortality as much as racial inequities do, it would need to assume two to three decades of mortality progress for Whites.

...addressing health disparities...would have reduced direct medical care expenditures by about $230 billion and indirect costs associated with illness and premature death by more than $1 trillion for the years”

• “For White mortality rates in 2020 to reach levels that Blacks experience any given year, White COVID-19 mortality would need to increase nearly 6-fold.”

• “Even amid COVID-19, US White mortality is likely to be less than what US Blacks have experienced every year.”
Latino life expectancy will decrease due to COVID-19

Abstract

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

Methods

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

Dr. Tom Frieden

Estimated cost of recent epidemics/pandemics:

SARS (2003) - $40 billion
H5N1 (2006) - $40 billion
H1N1 (2009) - $45 billion
Ebola (2014) - $55 billion
COVID-19 (2019) - $8.8 TRILLION

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

7:00 AM · Aug 20, 2020 · Twitter for Android
Possible ways forward
Medicaid expansion is gaining popularity

After victories, Medicaid expansion revisited in Mississippi
By LEAH WILLINGHAM  August 30, 2020

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

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

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

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation, waste management, and other services</td>
<td>167,000</td>
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<tr>
<td>Health care workers</td>
<td>155,000</td>
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<td>Grocery store workers, other retail</td>
<td>137,000</td>
</tr>
<tr>
<td>Food production</td>
<td>82,000</td>
</tr>
<tr>
<td>Other essential workers</td>
<td>109,000</td>
</tr>
</tbody>
</table>

Note: “Essential workers” refers to essential or front-line workers likely required to go to work despite stay-at-home orders. Fifteen states have not implemented the Affordable Care Act’s option to expand their Medicaid program to cover low-income adults.
Source: CBPP analysis of Census Bureau data
COVID-19 and identification of people with acute HIV

The emergency departments (ED) has been identified as a key location for HIV screening, with many new diagnoses resulting from new assumed ED screening programs [1]. The COVID-19 pandemic has greatly affected ED operations across the country. Many EDs have seen dramatic increases in patient volumes, while others have experienced a fall, likely only the most serious cases continue to arrive at the ED. Preparations for and management of COVID-19 are clearly preventing some patients from accessing EDs, but other health initiatives, such as expanded HIV screening and linkage to care, must continue. Routine HIV screening in the ED faces many barriers in normal times, due to competing priorities and complications of implementation [2].

The COVID-19 pandemic presents further challenges to routine screening programs. We describe how our urban ED in Chicago, with advance planning, was able to continue routine HIV screening in the face of the COVID-19 pandemic.

HIV Screening Program and ED Design

The University of Chicago has had a program for expanded HIV testing and linkage to care at our hospitals and clinics since 2011. Recently, the program has placed special emphasis on screening in the ED, utilizing automated electronic medical record (EMR) reminders to support test ordering. All ED patients under age 65 who have not been tested for HIV in the last year are eligible for screening. The HIV care team assess all patients who are identified with a negative result.

Increasing dx of acute HIV

- 6 to nearly 30 cases
- Primarily Black

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

- As low as 576–696 (1.6%–1.7%) fewer infections with 10% offered HIV testing (6.6% accepting a test)
- As high as 5840–7225 (16.3%–17.2%) fewer infections with 90% offered testing (59.3% accepting a test)
Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms

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

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

The next year, a randomized trial showed that a combination of hydralazine and nisoldipine diminished reduced mortality due to heart failure among patients who identified themselves as black. The Food and Drug Administration granted a race-specific indication for that product, BIBF, in 2005. Even though BIBF’s ultimate commercial failure casts doubt on race-based medicine, it did not stop the approach in race. Premenopausal women have repeatedly relied on algorithms to take race seriously, while distin-
guished social scientists vehemently contest these claims.

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

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

To illustrate the potential dangers of such practices, we have compiled a partial list of race-

adjusted algorithms (Table 1). We explore several of them in detail here. Given their potential to perpetuate or even amplify race-based health inequities, they merit thorough scrutiny.

CARDIOLOGY

The American Heart Association (AHA) Get with the Guidelines–Heart Failure Quality Initiative, a sub-

unit of the AHA, has been in place since 2002, and it has been a key part of the AHA’s efforts to improve the care of patients with heart failure. The initiative seeks to improve the quality of care for patients with heart failure by providing a framework for the development and implementation of evidence-based guidelines. The AHA recommends that all hospitals and health care systems participating in the initiative follow evidence-based guidelines and that patients receive care that is consistent with the latest evidence-based guidelines. The AHA also recommends that hospitals and health care systems participate in the initiative by implementing evidence-based guidelines and monitoring their performance.

In 2006, the AHA released the first edition of the Get with the Guidelines–Heart Failure Quality Initiative, which included evidence-based guidelines for the treatment of heart failure. The guidelines were based on a systematic review of the existing literature and were developed by a multidisciplinary team of experts in heart failure care. The guidelines were updated in 2010 and 2015, with the latest update released in 2015.

The guidelines are designed to help health care providers improve the quality of care for patients with heart failure by providing evidence-based recommendations for the diagnosis, treatment, and management of heart failure. The guidelines include recommendations for pharmacological therapy, device therapy, and non-pharmacological therapy. The guidelines also include recommendations for the prevention and treatment of complications associated with heart failure.

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Re-assess prevention/care algorithms or guidelines

Of the 31 men who seroconverted and had behavioral data to assess PrEP eligibility:
- 22 (65%) met current PrEP eligibility guidelines at baseline assessment.
- 7 of 8 (88%) white men and 15 of 23 (65%) black men who seroconverted met PrEP eligibility guidelines.
We can reduce health inequities

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

The Ryan White HIV/AIDS Program (RWAP), administered by the Health Resources and Services Administration (HRSA), supports health care and supportive services through a national network of Ryan White Health Systems grantees. The RWAP reduces health disparities through a four-part approach: (1) partnering with communities to identify and address the needs of those affected by HIV/AIDS, (2) expanding health care access and improved health outcomes for all people living with HIV/AIDS, (3) increasing the capacity of health care providers to care for people living with HIV/AIDS, and (4) enhancing the public’s understanding and acceptance of people living with HIV/AIDS.

RWAP DATA

The RWAP DATA project (http://rwapdata.hrsa.gov) is supported by HRSA and uses a validated HIV/AIDS surveillance dataset to monitor HIV/AIDS-related health disparities across the United States. The RWAP DATA project provides comprehensive data on the epidemiology of HIV/AIDS-related health disparities among racial, ethnic, and socioeconomic groups.


<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage Point Difference in Viral Suppression, 2010</th>
<th>Percentage Point Difference in Viral Suppression, 2016</th>
<th>Percentage Point Change in Difference, 2010-2016</th>
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<td>4.6</td>
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<tr>
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<tr>
<td>Asian</td>
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<tr>
<td>Black/African</td>
<td>10.8</td>
<td>6.1</td>
<td>4.7</td>
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SELECT RWAP DATA TOPOGRAPHIES

In 2016, the RWAP served 370,971 clients. The RWAP DATA project provides comprehensive data on the epidemiology of HIV/AIDS-related health disparities across the United States.

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

Christopher T. Rentschler,1,2, Farah Kidwai-Khan1,3, Janet P. Tate1,2, Lesley S. Park1,2, Joseph T. King, Jr.1,2,3, Melissa Sanderson1,4, Ronald G. Hauser1,6, Anna Schultz1,6, Christopher I. Jarvis,1,3 Mark Holodny1,2, Vincent Lo Re III1,7, Kathleen M. Akgun1,2, Kristina Coe Bthers2, Tamar H. Taddie1,4, Matthew S. Freiberg1,2,7, and Amy C. Justice1,4,13

Abstract

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

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

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

Conclusions: Black and Hispanic individuals are experiencing an excess burden of Covid-19 not entirely explained by underlying medical conditions or where they live or receive care. While there was no observed difference in mortality by race or ethnicity, our findings may underestimate risk in the broader US population as health disparities tend to be reduced in VA.
<table>
<thead>
<tr>
<th>Scenario 1: observed continuum (for each race)</th>
<th>Transmission rate*</th>
<th>Transmission rate ratio (black vs white)</th>
<th>Incidence rate†</th>
<th>Incidence rate ratio (black vs white)</th>
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<tr>
<td>White MSM</td>
<td>9710</td>
<td>3.99</td>
<td>0.32</td>
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<tr>
<td>Black MSM</td>
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<td>7.92</td>
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<table>
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<th>Black MSM receiving interventions in HIV care continuum‡</th>
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</tr>
<tr>
<td>Scenario 3: 95% diagnosis</td>
</tr>
<tr>
<td>7209</td>
</tr>
<tr>
<td>Scenario 4: 95% retention</td>
</tr>
<tr>
<td>7362</td>
</tr>
<tr>
<td>Scenario 5: concurrent 95% diagnosis and 95% retention</td>
</tr>
<tr>
<td>4066</td>
</tr>
</tbody>
</table>

(Rosenberg, 2014)
<table>
<thead>
<tr>
<th>Scenario 1: observed continuum (for each race)</th>
<th>Transmission rate*</th>
<th>Transmission rate ratio (black vs white)</th>
<th>Incidence rate†</th>
<th>Incidence rate ratio (black vs white)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White MSM</td>
<td>9710</td>
<td>3.99</td>
<td>..</td>
<td>0.32</td>
</tr>
<tr>
<td>Black MSM</td>
<td>9833</td>
<td>5.45</td>
<td>1.36</td>
<td>2.57</td>
</tr>
<tr>
<td>Black MSM receiving interventions in HIV care continuum‡</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scenario 2: racially equivalent care</td>
<td>7206</td>
<td>3.99</td>
<td>1.00</td>
<td>1.89</td>
</tr>
<tr>
<td>Scenario 3: 95% diagnosis</td>
<td>7209</td>
<td>3.99</td>
<td>1.00</td>
<td>1.89</td>
</tr>
<tr>
<td>Scenario 4: 95% retention</td>
<td>7362</td>
<td>4.08</td>
<td>1.02</td>
<td>1.93</td>
</tr>
<tr>
<td>Scenario 5: concurrent 95% diagnosis and 95% retention</td>
<td>4066</td>
<td>2.25</td>
<td>0.56</td>
<td>1.06</td>
</tr>
</tbody>
</table>

(Rosenberg, 2014)
COVID-19 and Aging with HIV

COVID-19 Takes Aim at Aging Black Americans

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

- Non-Hispanic Black
- Hispanic or Latino
- Non-Hispanic white

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Death Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>280</td>
</tr>
<tr>
<td>75-84</td>
<td>619</td>
</tr>
<tr>
<td>85 and older</td>
<td>1,265</td>
</tr>
</tbody>
</table>

Chart by Elizabeth Lucas and Lydia Zuraw/Kaiser Health News

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

Addressing differences in care long-term care facilities by income and protecting PLWH
We must think ahead about long-acting agents access to reduce inequities

**SCIENCE NEWS**
Long-Acting Cabotegravir Is an Effective PrEP Option for Women

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

**FDA approves first monthly injectable to treat HIV infection**

By ED SILVERMAN @Pharmalet

JANUARY 21, 2021

Reprints
Collaborations with other Federal Departments to reduce inequities

**Income**
- Working with DOL re: vocational training

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

**Housing**
- Working with HUD re: PLWH in mixed income housing

**Increasing healthcare access**
- Medicaid work requirements
- Public charge rule
Solicit insight and recommendations from outside experts

Exercise convening power for a day-long meeting with an expert panel
• Academics
• Healthcare providers
• PWAs

Recommend activities under HHS purview
• Short-term/long-term actions

Recommend activities outside HHS purview in conjunction with other agencies
• Short-term/long-term actions
Declare Racism a Public Health Issue
(What gets measured gets managed)

Racism, the public health crisis we can no longer ignore

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

When a single act of violence is captured and amplified on social media, much like the televised US civil rights protests of the 1960s, it brings police brutality into the consciousness of people across the world. It elicits a visceral response, and humanity joins they are based on race or ethnicity; in others, colour, caste, religious beliefs, Indigeneity or someone’s migratory status. However, the underlying oppression that caused these injustices to occur are largely similar. Racism and xenophobia are about division and control, and ultimately power. Together they constitute a structural form of violence that results, at the extreme, in innocent people being murdered.

The COVID-19 outbreak has uncovered a crisis in our social and political fabric extending beyond the outbreak itself: an uncomfortable propensity towards racism, xenophobia, and intolerance exacerbated by transnational health challenges and national politics. Internationally, we have witnessed the vilification of particular nationalities, with overt forms of sinophobia.³ Politically, xenophobia has been weaponised to enforce border controls against particular nationalities and undermine migrant rights.⁴ In the UK, minority ethnic groups are more likely to contract a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and, subsequently, face a higher risk of a severe form of illness.

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

The New York Times

Declare Racism a Public Health Emergency

It would be more than just a symbolic gesture.

By Abdullah Shi
Mr. Shihpar is a program impact initiatives manager in the Department
March 7, 2021

NIH Stands Against Structural Racism in Biomedical Research

I am proud to join my NIH colleagues today in reaffirming our commitment to fighting a disease that knows no boundaries, and that does not stop at a color line.
New pathogen, same disparities: why COVID-19 and HIV remain prevalent in U.S. communities of colour and implications for ending the HIV epidemic

Gregorio A. Millett

Abstract

Introduction: The U.S. Ending the HIV Epidemic (EHE) Initiative was launched in 2019 by PEPFAR and initially scaled up efforts to reduce HIV prevalence in the United States by 90% by 2030, with the goal of ending the HIV epidemic by 2030. The initiative aims to reduce HIV transmission by 90%, new HIV diagnoses by 90%, and HIV-related deaths by 90%.

Discussions: One of the many similarities between HIV and COVID-19 is their impact on communities of color. Research has shown that communities of color have a higher burden of HIV and COVID-19 infections, and these disparities are likely to persist in the post-COVID-19 world.

Keywords: disparities, COVID-19, HIV, racism, structural health inequalities

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

1 INTRODUCTION

The United States (US) is facing the HIV Epidemic (EHE) Initiative was launched in February 2019. The initiative seeks to reduce HIV transmission and new HIV diagnoses by 90% and HIV-related deaths by 90% by 2030. The initiative focuses on communities of color, which are disproportionately affected by HIV.

As early as mid-March 2020, 22% of US counties with greater than a seven percent population of Black residents (the national average) accounted for 52% of COVID-19 diagnoses and 57% of deaths nation-wide. As of early 2020, the disproportionate impact of COVID-19 has not only affected Black communities. The Centers for Disease Control and Prevention (CDC) reported that, in the first two months of data, the highest percentage of COVID-19 cases and deaths occurred in Black individuals, with rates higher than the national average.
Despite advances in HIV treatment and prevention, large inequalities still exist in the USA

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

Relative prevalence of HIV

- Men were 3-4 times more likely to have HIV than women
- Black women were 17-6 times more likely to have HIV than White women

Geographic map showing areas with higher prevalence of HIV across the USA.
Thank you.

Discussion